Wisconsin Department of Safety and Professional Services

Office Location: 4822 Madison Yards Way
Madison, WI 53705
Phone Number: (608) 266-2112

LicensE Portal: License.wi.gov
Email: dsps@wisconsin.gov
Website: http://dsps.wi.gov

HEARING AND SPEECH EXAMINING BOARD

SPEECH-LANGUAGE PATHOLOGIST

REQUEST FOR VERIFICATION OF CERTIFICATION

APPLICANT: Complete this section and submit to the American Speech-Language Hearing Association for completion at: American Speech-Language Hearing Association, 2200 Research Boulevard, Rockville, MD 20850-3289, (301) 296-5700. Form must be returned directly from the Association to the Department.

Last Name	**First Name**	**MI**	**Former / Maiden Name(s)**

Address (number/street)	(city)	(state)	(zip code)

Date of Birth	**Praxis ID or Social Security Number** (voluntary-for use in locating your records)	**Date of Graduation** (Anticipated dates of graduation will not be accepted.)
/ /	- -	/ /
Application Number	**Month/Year of Examination**	**Month/Year of Certification**
	/	/

ATTESTATION OF APPLICANT: I declare that I am the person referred to on this form and that all information required to be completed by me (the applicant for a credential), is complete and accurate to the best of my knowledge and belief. Furthermore, I declare that after completing the information that was required by me (and only that information) the form was forwarded to the relevant third-party for completion of the information asked of them. I also declare that to the best of my knowledge the completed form was provided to the Department of Safety and Professional Services by the relevant third-party (and not by me, the applicant). Finally, I declare that I understand that failure to provide the requested information, making any materially false statement and/or giving any materially false information in connection with my application for a credential may result in credential application processing delays; denial, revocation, suspension, or limitation of my credential; or any combination thereof; or such other penalties as may be provided by law. By signing below, I am signifying that I have read and understand the above declarations.

Applicant Signature (If unable to provide a digital signature, print and sign form.) **Date** / /

AMERICAN SPEECH-LANGUAGE HEARING ASSOCIATION: Please provide evidence that the above-named individual has successfully completed the PRAXIS examination and a post-graduate clinical fellowship year, or verification of certification of clinical competence. Forward evidence directly to the Department using the LicensE Third-Party* Upload Portal at license.wi.gov. You will need the application number shown above. (*For form completion purposes, the term "Third-Party" refers to any non-applicant or non-DSPS individual or entity submitting required documentation in support of a credential application.)

ATTESTATION OF THIRD-PARTY PROVIDING INFORMATION RELATED TO APPLICANT: I declare, on behalf of the third-party asked to provide information related to the applicant identified on this form, that the information provided is true and correct to the best of my knowledge and belief. I further declare that after completing the form I, or other third-party staff, will provide the completed form directly to the Wisconsin Department of Safety and Professional Services for review. By signing below, I am signifying that I have read, understand, and have complied with the above declarations.

Signature (If unable to provide a digital signature, print and sign form.) **Date** / /

Printed Name **Phone** - - Ext_____

Title:

Address (number/street)	(city)	(state)	(zip code)