

Wisconsin Department of Safety and Professional Services

Mail To: P.O. Box 8935
 Madison, WI 53708-8935
FAX #: (608) 251-3036
Phone #: (608) 266-2112

Ship To: 4822 Madison Yards Way
 Madison, WI 53705
E-Mail: dsps@wisconsin.gov
Website: <http://dsps.wi.gov>

COSMETOLOGY EXAMINING BOARD EMPLOYMENT VERIFICATION

APPLICANT: Complete top portion of this form and forward to past or present employer. Proper completion of this form is required for processing of the application. Failure to submit proper documentation of employment will delay processing of your credential application.

Last Name <input type="text"/>	First Name <input type="text"/>	MI <input type="text"/>	Former / Maiden Name(s) <input type="text"/>
Address (street, city, state, zip) <input type="text"/>			Date of Birth <input type="text"/> / <input type="text"/> / <input type="text"/>
I hereby authorize the employer named below to provide the Department with the information requested below.			
Applicant Signature: <input type="text"/>		Date: <input type="text"/> / <input type="text"/> / <input type="text"/>	
Email: <input type="text"/>			

PAST OR PRESENT EMPLOYER: Certify employment below and return directly to DSPS. You may fax/email to: (608) 251-3036 or DSPSCREDBAC@wisconsin.gov.

Cosmetology Manager/Owner Name <input type="text"/>	Check One: <input type="checkbox"/> Cosmetology Manager <input type="checkbox"/> Owner
Establishment Name <input type="text"/>	Establishment License Number <input type="text"/>
Establishment Address (street, city, state, zip) <input type="text"/>	
Employment Period: (include month, day, and year) From: <input type="text"/> / <input type="text"/> / <input type="text"/> To: <input type="text"/> / <input type="text"/> / <input type="text"/>	
Hours Worked:	Number of Hours Per Week: <input type="text"/>
<input type="checkbox"/> Full-Time	Number of Hours Per Week: <input type="text"/>
<input type="checkbox"/> Part-Time	Total Numbers of Hours Worked: <input type="text"/>
Employee Worked as: (check one) <input type="checkbox"/> Aesthetician <input type="checkbox"/> Cosmetologist <input type="checkbox"/> Electrologist <input type="checkbox"/> Manicurist	
I declare, as the Cosmetology Manager or Owner, the foregoing statements are true to the best of my knowledge and belief, and that I personally completed and signed this form.	
Signature of Cosmetology Manager or Owner <input type="text"/>	Date <input type="text"/> / <input type="text"/> / <input type="text"/>
Address (street, city, state, zip) <input type="text"/>	License Number: <input type="text"/>