Washington State Department of HEALTH

Hearing and Speech Credentialing
P.O. Box 47877
Olympia, WA 98504-7877
360.236.4700

# Audiologist
# Delegation of Supervision

| Name of supervisor of record | | | License number |
|---|---|---|---|
| Name of permit holder | | | Permit Number |
| Supervisor's business address | | | |
| City | State | Zip | Telephone (enter 10 digit #) |

## Delegation to Audiologist

| Name of delegated audiologist | | | |
|---|---|---|---|
| Delegated audiologist's signature | | | Date |
| License Number | First issue date | | |
| Business Address | | | |
| City | State | Zip | Telephone (enter 10 digit #) |

## Duration of Training

| From | To |
|---|---|
| | |

## Delegated Supervisor's Attestation

I _____ , do hereby certify that
Name of delegated supervisor

_____ will work under my supervision
Name of permit holder

performing all audiology and fitting and dispensing services during the interim permit period.

_____ _____
Signature of delegated supervisor Date

☐ Approval _____

☐ Denial _____