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 _____