



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

Hearing and Speech Attestation

Name of Practitioner:	
Credential Type:	Credential Number:
<p>I have completed the following:</p> <ul style="list-style-type: none"> • Continuing education, if required; • I have properly calibrated testing equipment; and • I am covered by a surety bond or maintain security in lieu of a surety bond per RCW 18.35.240. <p>I affirm the information I provided for the renewal of my credential is true and accurate to the best of my knowledge. In addition, if I have continuing education and/or other requirements due, I affirm I have met those requirements and I will provide documentation to the Department of Health upon request.</p>	
Signature of Practitioner:	
Date:	

Mail this document with your check or money order to:

Department of Health
 PO Box 1099
 Olympia, WA 98507-1099

Documents without a check or money order:

Department of Health
 Office of Customer Service
 PO Box 47865
 Olympia, WA 98504-7865

If you have any questions, please contact the Health Systems Quality Assurance Division, Customer Service Center.

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 Fax: 360-236-4818
 Email: hsgarenewalresearch@doh.wa.gov