Virginia Department of Health Professions
Board of Audiology and Speech-Language Pathology

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EMPLOYMENT VERIFICATION

APPLICANT INFORMATION – **To be completed by applicant.** Please type or print.			
Last Name:	First Name:	Middle Initial:	Other Names Used:
I hereby authorize the release of employment verification to the Virginia Board of Audiology and Speech-Language Pathology.			
Signature:		Date:	

EMPLOYER OR AUTHORIZED REPRESENTATIVE – **To be completed by employer or authorized representative and mailed directly to the Board.** The individual named above is applying for licensure as an Audiologist or Speech-Language Pathologist in the Commonwealth of Virginia. Please verify the employment history and status of this individual. In lieu of completion of this form, an employer may send an email or letter confirming requested information. If providing via fax, please provide cover sheet as well. **Board staff will not accept faxes without a cover sheet.**	
Employer's Business or Organization Name:	
Type of Business:	
Business Address:	
Phone:	Email Address:
Employee Name:	Position Title:
Employment Begin Date (mm/dd/yyyy)	Employment End Date (mm/dd/yyyy)
Provide all practice locations and dates of employment. If more space is required, list on separate paper.	
Practice Locations	Dates of Employment
Print Name	Signature and Date