Wyoming Board of Hearing Aid Specialists
2001 Capitol Avenue, Room 127
Cheyenne WY 82002

REQUEST FOR LICENSURE VERIFICATION

1. Applicant Information

Last Name	*First Name*	*Middle Initial*	*Previous Names Used*
Mailing Address	*City*	*State*	*Zip*
Phone	*E-Mail*		

STOP

The rest of this form must be completed by the state regulatory agency.

2. State Regulatory Agency

Agency Name			
Mailing Address	*City*	*State*	*Zip*
Phone	*E-Mail*		

Regarding the applicant listed in Section 1, our records show:

Name		*License #*
License Type/Classification	*Original Issue Date*	*Expiration Date*
Status ☐ Active ☐ Inactive ☐ Expired ☐ Retired ☐ Other _____	*Licensed By* ☐ Examination ☐ Reciprocity/Endorsement ☐ Other _____	

Has this applicant ever been denied licensure, certification or registration by your agency?	☐ Yes	☐ No
Has this applicant's license, certification, registration ever been in a probationary status, voluntarily surrendered, revoked, suspended, or limited in any way? (If "YES" please attach a copy of the Consent Agreement or the Findings of Facts, Conclusions of Law and Order.)	☐ Yes	☐ No

This form was completed by:

Name (please print)	*Title*

OFFICIAL SEAL

Signature *Date*