# VERIFICATION OF LICENSE
## Speech Pathologist/Audiologist

Access this form via website at: **hawaii.gov/dcca/pvl**

Hawaii Board of Speech
Pathology and Audiology
DCCA, PVL Licensing Branch
P.O. Box 3469
Honolulu, HI 96801

**TO BE COMPLETED BY APPLICANT:**

**APPLICANT**

| Name (Individual - First, Middle, Last): | Social Security Number: |
|---|---|
| Address (Include suite no., city, state and zip code): | License Number: |
| Mailing Address, **ONLY** if different from above (Include suite no., city, state and zip code) : | Date Issued: |

I hereby authorize the licensing agency of the state of Hawaii Board of Speech Pathology and Audiology. to furnish the information below to the

SIGN HERE:_____ TITLE: Date:

**TO BE COMPLETED BY LICENSING AGENCY:**

**LICENSING AGENCY**

This is to certify that the above-named entity or individual was issued license number:
to provide services in your state as a Naturopathic Physician:

Date issued:

Date license/certificate expires:

License status: current and in good standing

lapsed since: _____

inactive since: _____

Has this license/certificate ever been encumbered in any way (revoked, suspended, surrendered, limited, placed on probation, currently pending disciplinary action, being investigated)? . . . . . YES NO
***(Please explain "Yes" response and attach copy of board's final order and related information.)***

Do your files contain any derogatory information on this applicant? . . . . . YES NO
***(Please explain "Yes" response and attach copy of board's final order and related information.)***

COMMENTS:

Signature:

Title:

State:

Date:

***BOARD SEAL***

*TO THE APPLICANT: Attach original, with board's seal, to your application form.*

This material can be made available for individuals with special needs. Please call the Licensing Branch Manager at (808) 586-3000 to submit your request.