DC | HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA
Health Systems & Preparedness Administration

Applicants: The supervisor must complete this form **and** send it directly to the DC Board of Rehabilitative Therapies via email (dcboaud@dc.gov).

DC Board of Rehabilitative Therapies

Verification of Satisfactory Completion of Audiology Clinical Training

I hereby declare that ____
Name of Applicant

Address ____

an applicant for DC licensure in audiology, was employed as a professional in that field

from_________________ to____________ for____________ hours per week.
(mm/dd/yyyy) (mm/dd/yyyy)

The place of employment was ____
Facility Name

____
Address City State Zip Code

I further declare that the applicant was supervised by ______________________________
Printed Name of Supervisor

At that time the supervisor held:

{ } DC License in Audiology
{ } ABA/ASHA Certification in Audiology
{ } A License in Audiology from ______________________________________
State
whose licensure requirements were equivalent to ASHA certification or ABA certification.

I certify that the applicant was employed as a professional in the field of audiology under supervision and that the information provided above accurately reflects the hours and activities completed in accordance with DC Municipal Regulations for Audiology.

____
Signature of Supervisor, Current Clinical Director, or HR Department Title

____
Current Phone Number Date

Revised February 2026