



Bureau of Professional Licensing  
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### CLINICAL AUDIOLOGY WORK EXPERIENCE

Authority: 1978 PA 368

This form must be submitted directly to this office by the supervisor who is verifying your clinical audiology experience. If this form is submitted by the applicant, it will not be accepted.

**To be Completed by Applicant:**

Applicant's Name (First, Middle, Last)		Date of Birth
Address		
City	State	Zip Code
Telephone Number	E-mail Address	
Applicant Signature		Date

**To be Completed by Supervisor:**

<b>CERTIFICATION AND SIGNATURE</b>	
I certify the applicant named above practiced audiology under my supervision as defined in MCL 333.16109(2)(b) beginning on _____ and ending on _____.	
(Month/Day/Year) (Month/Day/Year)	
at _____	
(Name of Agency)	
located at _____	
(Address of Agency)	
_____ Signature and Title	_____ Date
_____ Print or Type Name	_____ Type of License/Registration held and State held in