



**State of Nevada
Speech-Language Pathology, Audiology & Hearing Aid Dispensing Board**

UNLICENSED PRACTICE REPORT

PART I: REPORT FILED AGAINST (Respondent)

INSTRUCTIONS

Per [NRS 63B.290](#)(1), "a person shall not engage in the practice of audiology, speech-language pathology or fitting and dispensing hearing aids in this State without holding a valid license issued pursuant to the provisions of this chapter." As such, our Board receives and investigates reports of alleged unlicensed practice and initiates administrative action as necessary to ensure the welfare and safety of the public.

Name of Individual: _____

Company/Agency (if applicable): _____

Address: _____

Telephone: _____ **Email:** _____

PART II: REPORTER FILED BY (Reporter)

INSTRUCTIONS

Please note that it is likely that you will be contacted by Board staff for an interview and/or to provide additional information. Should the case proceed to a Hearing before the Board, you may also be called as a witness. The person filing the Report is referred to as the "Reporter."

You may also choose to remain anonymous, however the Board may refuse to consider the Report if anonymity makes processing the report impossible or unfair to the Respondent.

Name: _____

Company/Agency: _____

Address: _____

Telephone: _____ **Email:** _____

OR I wish to remain Anonymous

PART III: SUMMARY OF ALLEGED UNLICENSED PRACTICE

INSTRUCTIONS

Please summarize the details of the alleged unlicensed practice as clearly and as completely as possible. Include names of all individuals who may have relevant knowledge or information regarding the circumstances or allegations contained in the report. Note that the case may be closed or dismissed if there is insufficient evidence provided to investigate or substantiate the claim.

Date/Date Range of Alleged Unlicensed Practice (if applicable):

Please describe the alleged unlicensed practice in as much detail as possible below:

Include enough detail to allow the Board to understand the allegations and to allow the Respondent to prepare a defense. You may attach additional pages and include any documents you believe are relevant.

Please list all other agencies or organizations you have contacted about this report:

Name/Company

Telephone

Is the Report regarding services provided to you as a Patient? Yes No
If "yes", please complete *Release of Medical Records* on the next page.

Is the Report regarding the fitting and dispensing of Hearing Aids? Yes No
If "no", please skip to Part IV.

If "yes", please complete section below and attach copies of 1) the Bill of Sale, and 2) a copy of the refund response from Provider (if applicable).

Date of Purchase of Hearing Aids: _____

Date Hearing Aids Received and Fitted into Ear(s): _____

Date Hearing Aids Returned to Provider: _____

Date Refund Requested from Provider: _____

PART IV: CERTIFICATION OF REPORTER

I hereby certify that all information which I have given to be true, accurate and complete to the best of my knowledge.

Signature: _____ **Date:** _____

PART V: SUBMISSION AND FOLLOW-UP

Please return this form to the Board Office via one of the following methods:

Email: board@nvspeechhearing.org

USPS Mail: 6170 Mae Anne Avenue, Suite 1, Reno, NV 89523

Fax: (775) 746-4105

Please also note:

- Reports of unlicensed practice are handled by the Board's Executive Director, Investigator, and Board Counsel.
- Details of a case are not disclosed to the Board unless or until action is initiated pursuant to [NRS 637B.290](#).
- Board staff cannot provide legal advice.

Please visit our website at

<https://www.nvspeechhearing.org/consumer/complaint/unlicensedpractice.asp> to learn more about the process of investigating reports of unlicensed practice, including Board response, timeframes, and outcomes.

For Official Use Only Date Received: _____ Case #: _____



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RELEASE OF MEDICAL RECORDS

I, _____, hereby authorize any of the following: Physician, Psychologist, Health Professional, Hospital, Clinic, Hearing Aid Center, office or other related facility or provider to release information from my medical records to the State of Nevada, Speech-Language Pathology, Audiology and Hearing Aid Dispensing Board at the above address.

It is understood that this release will be used in the following manner:

1. The information requested/received will be used only for the investigation of my Report of Unlicensed Practice filed with, and in accordance with the authorized responsibilities of the Board, and;
2. All information may be released, including, medical and/or psychological, history, physical and/or mental condition(s), diagnosis, prognosis, treatment, laboratory reports, testing results, client records and all professional(s)'s notes.
3. This release shall be valid for one year from the date of signing.
4. A copy of this release is as valid as the original.

Signature of Patient/Client/Reporter

Date

Signature of Parent/Guardian (if required)

Date

Signature of Witness

Date