

SOUTH DAKOTA DEPARTMENT OF LABOR AND REGULATION  
**SOUTH DAKOTA COSMETOLOGY COMMISSION**

217 W. Missouri Ave., Pierre, SD 57501  
Tel: 605.773.6193 Fax: 605.773.7175 cosmetology.sd.gov

**OUT-OF-STATE WORK EXPERIENCE AFFIDAVIT**

***PLEASE BE ADVISED THAT IN SOUTH DAKOTA SUPPLYING FALSE INFORMATION ON THIS FORM WHICH BECOMES PART OF AN APPLICATION IS PUNISHABLE BY LAW.***

Fill, print, sign, and mail this application or print and print all information legibly. **APPLICANT** - Work experience must be within the last five years. If the work experience was obtained more than five years before the date of this application, the applicant must take a Commission-approved safety and infection control course in order to receive credit for the work experience. Contact the Commission office for further information.

**EMPLOYEE INFORMATION** (completed by employee/applicant)

Employee Name: \_\_\_\_\_

Employee Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**WORK INFORMATION** (must be completed by salon manager, salon owner, or person signing this form\*)

*\*Cannot be signed by the employee. If the employee is the owner or manager, then someone else such as an accountant must complete and sign this form.*

Salon Name: \_\_\_\_\_ Owner/Manager Name: \_\_\_\_\_

Salon Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Salon Telephone: \_\_\_\_\_

Employment Dates: Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_ Total Hours: \_\_\_\_\_

**I declare and affirm under the penalties of perjury that this information has been examined by me, and to the best of my knowledge and belief is, in all things true and correct.**

Signed \*: \_\_\_\_\_  
(person signing must have document notarized)

Telephone number: \_\_\_\_\_

Subscribed and sworn to me before this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

(seal) \_\_\_\_\_  
Notary Public signature

My commission expires: \_\_\_\_\_