BOARD OF HEARING AID SPECIALISTS
STATE OF FLORIDA
TRAINING PROGRAM REGISTRATION
APPLICATION AND INSTRUCTIONS

You may read the laws and rules in order to determine your eligibility to sit for the examination. Chapter 484, Part II Florida Statutes (F.S.) and Rule Chapter 64B6, Florida Administrative Code (F.A.C.) can be found on our web site at http://floridashearingaidspecialists.gov/.

Credentials required for licensure and/or examination eligibility:

- Submit a completed application with required fees.
- Proof of an eligible sponsor. Sponsor must submit proof of being board certified by the National Board for Certification in Hearing Instrument Sciences. The sponsor must have been actively practicing for the last two (2) consecutive years immediately prior to sponsorship and who must not have been disciplined during the past four (4) years.
- License/Certification Verification form must be completed **IF** you hold or ever held a license or certification in any state, U.S. territory, or foreign country. You may us the form attached or have each agency mail a verification of licensure directly to this office.

REQUIRED FEES
Submit with this application a check or money order made payable to the Department of Health in the amount of $105.00 which is a non-refundable $100.00 registration fee plus a special fee of $5.00 to fund efforts to combat unlicensed activity.

SECURING AN ELIGIBLE SPONSOR
An applicant shall secure the supervision of a sponsor who must have possessed an active license and have been actively practicing for at least two (2) consecutive years immediately prior to sponsorship and who must not have been disciplined during the past four (4) years. The sponsor must submit official documentation of being Board certified by the National Board for Certification in Hearing Instrument Sciences with each application.

The trainee may change sponsors twice during the training program by checking "Change of Sponsor" on the Sponsor Registration Form, having it signed by the new sponsor and submitting for approval. Make copies of this form and keep for future use by sponsors. The **two-page** Sponsor Report Form should be kept by the sponsor and must be submitted upon completion of the program or termination of the program.

ADDRESS CHANGE
If you have a change of address, you must provide signed, written notification to the Board office. Include your full name, old address, and new address, and whether this is your mailing address or your location address.

NAME CHANGE
If you have a legal name change, you must provide signed, written notification to the Board office. Include your full name as you applied, your new name, and a photocopy of the applicable legal document. Your name can not be changed without valid legal documentation.

TRAINING PROGRAM STAGES

A training program shall be a minimum of six months in length and shall be divided into four stages.

- State I: During this stage, the trainee is required to complete the International Hearing Society Home Study Course and shall submit proof of passing the home study course final examination **before beginning work.**

Following the completion of Stage I, the trainee shall be in training for the dispensing of hearing aids for a minimum of twenty (20) hours each week, and shall be under the direct supervision of the sponsor at all times when performing the functions of a hearing aid specialists.

- Stage II – 1 month: During this stage, the trainee may perform audiometric tests, and make ea mold impressions and modification, but the sponsor or hearing aid specialist designated by the sponsor shall be physically present, in the same room at all times when the trainee is performing these functions. The trainee may not recommend the selection of a hearing aid, dispense a hearing aid, or counsel a client.
- Stage III – 2 months: During this stage the trainee may perform all tasks in Stage II, recommend the selection of a hearing aid, and counsel a client, but the trainee shall be under the direct supervision of the sponsor or hearing aid specialist designated by the sponsor. The trainee may not deliver a hearing aid.
- Stage IV – 3 months: During this Stage the trainee may perform all the tasks in Stages II and III and deliver hearing aids, but the sponsor or hearing aid specialist designated by the sponsor shall be physically present in the same room at the time a hearing aid is delivered to the client, and the receipt required by Sections 484.051, F.S., must have the signature and license number of the sponsor or hearing aid specialist designated by the sponsor.

MAIL APPLICATION PACKET AND FEE TO:
BOARD OF HEARING AID SPECIALISTS
PO BOX 6330
TALLAHASSEE, FLORIDA 32314-6330

CORRESPONDENCE BEING MAILED SEPERAT FROM THE APPLICATION – MAIL TO:
BOARD OF HEARING AID SPECIALISTS
4052 BALD CYPRESS WAY, BIN C08
TALLAHASSEE, FLORIDA 32399-3258

LICENSEE INFORMATION ON THE INTERNET: When you become licensed your name, license number and practice location address will be accessible through our Web site. The application asks for two addresses, a mailing address and a practice location address. All documents, including your license, will be sent to your mailing address. Your practice location address will be printed on your license and will show as your address of record on our Web site, which provides the public with information on licensed health care practitioners in the State of Florida. If you only provide one address, it will be used for both the mailing address and the practice location address.

COMPLETING THE APPLICATION

Questions must be answered fully and truthfully. Obtaining a license by fraudulent misrepresentation is grounds for denial of your application or revocation of your license. You must sign and date the application. Original forms must be submitted; photocopies of signatures are not acceptable. It is your responsibility to notify this office in writing if the answers to any of these questions change.

1. **APPLICANT PROFILE DATA:** Print neatly in black ballpoint pen or type all information. Providing an email address is optional. If you provide one, it will become public record. However, providing an email address will expedite communications with the Department.

2. **SPONSOR INFORMATION:** Submit a photocopy of your sponsor's proof of being Board certified by the National Board for Certification in Hearing Instrument Sciences.

3. **APPLICANT HISTORY:**
   IMPORTANT NOTICE- Applicants for licensure, certification or registration and candidates for examination may be excluded from licensure, certification or registration if their felony conviction falls into certain timeframes as established in Section 456.0635(2), Florida Statutes. If you answer YES to any questions in this section, please provide a written explanation for each question including the county and state of each termination or conviction, date of each termination or conviction, and copies of supporting documentation which includes court dispositions or agency orders where applicable.

4. **APPLICANT HISTORY – PROFESSIONAL:** Please read carefully. If you answer "yes", please provide supporting documentation.

5. **APPLICANT HISTORY – GENERAL:** Please read carefully. If you answer "yes", please provide supporting documentation.

6. **APPLICANT LICENSURE STATUS:** Complete this section listing any state (including Florida), U.S. territory, or foreign country that you hold or ever held a license to practice as a hearing aid specialist.

7. **APPLICANT STATEMENT:** Read this section carefully. Your signature is required.

8. **SOCIAL SECURITY NUMBER:** Your social security number is required.

9. **APPLICANT HISTORY – HEALTH:** The board reviews each applicant's history to determine that the applicant is able to practice profession with reasonable skill and competence. Please read these questions very carefully. If you answer "yes" to any question(s) in this section, you must provide the Board complete details.

LICENSE/CERTIFICATION VERIFICATION FORM: This form is only to be completed if you hold or have held a license in another state, U.S. territory, or foreign county. You must mail this form to the office that issued the license or certification. That office must complete and mail the form directly to the Board office. **It will not be considered official if received from the applicant.**

PLEASE NOTE: Prior to initial licensure, you will be required to attend a Board-approved continuing education course in laws & rules.

Hearing Aid Specialists Training Program Registration Application

1. APPLICANT PROFILE DATA *(PLEASE TYPE OR PRINT IN BLACK INK)*

Name	Last	First	Middle
Mailing Address	No. and Street .		Apt. No.
	City	State	Zip Code
Business Name	Business Name		
* Practice Location Address	No. and Street		Apt. No.
	City	State	Zip Code

DO NOT WRITE IN THIS SPACE
FOR OFFICE USE ONLY

E-mail Address:

Date of Birth: _____/_____/_____

Have you ever changed your name through marriage or through action of a court, or have you ever been known by any other name?
☐YES ☐NO If "YES", list name(s) and date(s) of changes:

_____

_____

Home Telephone: Area Code ( )	Business Telephone: Area Code ( )	Fax Number: Area Code ( )
E-Mail Address: (optional)		Sex: ☐ Male ☐ Female

We are required to ask that you furnish the information as part of your voluntary compliance with Section 2, Uniform Guidelines on Employee Selection Procedure (1978) 43 CFR38295 and 38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

Race: ☐ white ☐ Black or African-American ☐ Hispanic ☐ Asian ☐American Indian or Alaska Native ☐ Native Hawaiian or other Pacific Islander ☐ Two or More Races Sex: ☐ Male ☐ Female

2. SPONSOR INFORMATION

Primary Sponsor's Name & Address: _____

License No.:_____ ☐ I have attached a copy of my current NBC/IHS certification.

Designee's Name & Address: _____

License No.:_____ ☐ I have attached a copy of my current NBC/IHS certification.

* Your Practice Location Address will show on the Internet License Verification screen, which provides the public with information on licensed health care practitioners in the State of Florida.

If you only provide one address, it will be used for both the mailing address and the practice location address.

The practice location address must be a street address.

APPLICANT NAME _____

3.	**APPLICANT HISTORY – IMPORTANT NOTICE**: Applicants for licensure, certification or registration and candidates for examination may be excluded from licensure, certification or registration if their felony conviction falls into certain timeframes as established in Section 456.0635(2), Florida Statutes. If you answer YES to any of the following questions, please provide a written explanation for each question including the county and state of each termination or conviction, date of each termination or conviction, and copies of supporting documentation to the address below. Supporting documentation includes court dispositions or agency orders where applicable.	
1.	Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, F.S. (relating to social and economic assistance), Chapter 817, F.S. (relating to fraudulent practices), Chapter 893, F.S. (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction? (If you responded "no", skip to #2.)	☐Yes ☐No
a.	If "yes" to 1, for the felonies of the first or second degree, has it been more than 15 years from the date of the plea, sentence and completion of any subsequent probation?	☐Yes ☐No
b.	If "yes" to 1, for the felonies of the third degree, has it been more than 10 years from the date of the plea, sentence and completion of any subsequent probation? (This question does not apply to felonies of the third degree under Section 893.13(6)(a), Florida Statutes).	☐Yes ☐No
c.	If "yes" to 1, for the felonies of the third degree under Section 893.13(6)(a), Florida Statutes, has it been more than 5 years from the date of the plea, sentence and completion of any subsequent probation?	☐Yes ☐No
d.	If "yes" to 1, have you successfully completed a drug court program that resulted in the plea for the felony offense being withdrawn or the charges dismissed? (If "yes", please provide supporting documentation).	☐Yes ☐No
2.	Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)?	☐Yes ☐No
a.	If "yes" to 2, has it been more than 15 years before the date of application since the sentence and any subsequent period of probation for such conviction or plea ended?	☐Yes ☐No
3.	Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes? (If "No", do not answer 3a.)	☐Yes ☐No
a.	If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years?	☐Yes ☐No
4.	Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program? (If "No", do not answer 4a or 4b.)	☐Yes ☐No
a.	Have you been in good standing with a state Medicaid program for the most recent five years?	☐Yes ☐No
b.	Did the termination occur at least 20 years before the date of this application?	☐Yes ☐No
5.	Are you currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities?	☐Yes ☐No

APPLICANT NAME _____

4. APPLICANT HISTORY – PROFESSIONAL		
1.	Have you ever been denied licensure, certification, or registration for the dispensing of hearing aids or any health-related profession or the renewal thereof in any state?	☐Yes ☐No
2.	Have you ever been denied the right to take a Hearing Aid Specialists licensure examination?	☐Yes ☐No
3.	Have you ever had a license to practice a profession revoked, suspended, or otherwise acted against in a disciplinary proceeding in any state?	☐Yes ☐No
4.	Are you now or have you ever been a defendant in civil litigation in which the basis of the complaint against you was alleged negligence, malpractice or lack of professional competence?	☐Yes ☐No
5.	Is there currently pending, in any jurisdiction, a complaint or investigation against your professional conduct or competency?	☐Yes ☐No
If you answered "YES" to any question in Section 5, you must provide the Board complete details.		

5. APPLICANT HISTORY – GENERAL		
1.	Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to any crime in any jurisdiction, other than a minor traffic offense? You must include all misdemeanors and felonies, even if adjudication was withheld by the court so that you would not have a record of conviction. Driving under the influence or driving while impaired is not a minor traffic offense for purposes of this question. If you answer YES, you must explain in detail on a separate sheet. In your explanation, include dates, jurisdictions, offenses, specific circumstances, and dispositions. You must include a certified copy of the court records/dispositions.	☐Yes ☐No

APPLICANT NAME _____

6. APPLICANT LICENSURE STATUS

A. Do you hold or have you ever held a license to practice as a hearing aid specialist in any state (including Florida), U.S. territory, or foreign country? ❑ YES ❑ NO If YES, list all licenses and the issuing state, territory, or foreign country:

B. Do you have any applications for licensure as a hearing aid specialist currently pending in any state (including Florida), U.S. territory, or foreign country? ❑ YES ❑ NO If YES, list all pending applications and the issuing state, territory, or foreign country:

7. APPLICANT STATEMENT

I hereby authorize all hospitals, institutions, or organizations, personal physicians, employers (past or present), business and professional associates (past or present), and all government agencies and instrumentality's (local, state, federal, or foreign) to release to the Department of Health any information, files, or records requested by the Department in connection with the processing of this application. I further authorize the Department to release to the organizations, individuals, and groups listed above any information which is material to my application.

I understand that it is my duty and responsibility as an applicant for licensure to supplement my application after it has been submitted if and when any material change in circumstances or conditions occur which might affect the Board's decision concerning my eligibility for examination or licensure. Such supplement is required by Chapter 456.013(1)(a) F.S. Failure to do so may result in disciplinary action by the Board including denial of licensure.

I have carefully read the questions in the foregoing application and have answered them truthfully and completely without reservations of any kind. Should I furnish any false information on this application, I hereby acknowledge that such act shall constitute cause for denial, suspension, or revocation of any license to practice in the State of Florida the profession for which I am applying. I declare that I am the person referred to in the foregoing application. I further state that I will comply with all requirements for licensure renewal in effect at the time of license renewal including submission of appropriate renewal fees and continuing education credits.

I hereby acknowledge that practice as a licensed Hearing Aid Specialist in Florida is governed by Chapters 456 and, Part II, Florida Statutes, and Chapter 64B6, Florida Administrative Code. I understand that I am under a continuing obligation to understand and keep informed of any changes to Chapters 456 and 484, Part II, F.S. and Chapter 64B-6, Florida Administrative Code.

_____ _____

Applicant's Signature Date

CONFIDENTIAL AND EXEMPT FROM PUBLIC RECORDS DISCLOSURE

Florida Department of Health

Board of Hearing Aid Specialists

This page must be returned, but is exempt from public records disclosure. The Department of Health is required and authorized to collect Social Security Numbers relating to applications for professional licensure pursuant to Title 42 USC § 466 (a)(13). For all professions regulated under chapter 456, Florida Statutes, the collection of Social Security Numbers is required by section 456.013(1)(a),

Name: _____

Last **First**
Middle

8. Social Security Number: _____-_____-_____

9. APPLICANT HISTORY – HEALTH
If you answer "YES" to any of the following questions, you must provide complete details.

A.	In the last 5 years, have you been enrolled in, required to enter into, or participated in any drug or alcohol recovery program or impaired practitioner program for treatment of drug or alcohol abuse that occurred within the past 5 years?	❑ YES ❑ NO
B.	In the last 5 years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental disorder or impairment?	❑ YES ❑ NO
C.	During the last 5 years, have you been treated for or had a recurrence of a diagnosed mental disorder that has impaired your ability to practice your profession within the past 5 years?	❑ YES ❑ NO
D.	In the last 5 years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol/drug) disorder or, if you were previously in such a program, did you suffer a relapse within the last 5 years?	❑ YES ❑ NO
E.	During the last 5 years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol/drug) disorder that has impaired your ability to practice your profession within the past 5 years?	❑ YES ❑ NO
F.	During the last 5 years, have you been treated for or had a recurrence of a diagnosed physical disorder that has impaired your ability to practice your profession?	❑ YES ❑ NO

BOARD OF HEARING AID SPECIALISTS

SPONSOR REGISTRATION FORM

☐ **Check here only if this is a Change of Sponsor** (Trainee AT No._____required for change.)

- Complete **all** sections of this form.
- When changing to a different sponsor, mail/fax (850) 921-5389 the completed form with verification of sponsor's National Board Certification in Hearing Instrument Sciences PRIOR to beginning work under the new sponsor. You will not receive credit for hours worked until the Board has received this form and approves your new sponsor.
- Read Rule Chapter 64B6-8, Florida Administrative Code
- Please print clearly or type all information.

Trainee Name _____ Date of Birth _____

Sponsor Name _____ License Number _____ Business Name _____

Training Site Address _____ Suite Number _____ Business Phone _____

City _____ State _____ Zip _____ Fax Number _____

Designee Name (If applicable) _____ License Number _____

LIST NAMES OF OTHER TRAINEES CURRENTLY UNDER YOUR SUPERVISION:

_____

_____

I declare that I have an active Florida license and have been actively practicing under this license for at least two consecutive years immediately prior to this sponsorship; I have not been disciplined by the Board of Hearing Aid Specialists during the past four years; and I understand my responsibilities and the limitation of being a sponsor for a Training Program, pursuant to 484, Part II, F.S. and Chapter 64B6, F.A.C. In addition, I state that I now and will in the future notify the Board of Hearing Aid Specialists upon my designation of another licensed hearing aid specialist to assist in this Training Program; will notify the Board upon training being conducted at a location other than that identified above; and upon Trainee's completion of the program or termination of my sponsorship.

I declare that all statements made herein and herewith are true and correct and certify that I have enclosed proof of National Certification.

SPONSOR SIGNATURE _____ DATE _____

DESIGNEE SIGNATURE (If applicable) _____ DATE _____

LICENSE/CERTIFICATION VERIFICATION

APPLICANT NAME _____

Print clearly in black ink or type the information.

Applicant's Address:
Title of License: License Number:

THE FOLLOWING SECTIONS MUST BE COMPLETED BY THE STATE LICENSING BOARD OFFICE AND MAILED DIRECTLY TO:

BOARD OF HEARING AID SPECIALISTS
4052 Bald Cypress Way, BIN #C08
TALLAHASSEE, FLORIDA 32399-3258

The individual listed above has applied for licensure in Florida. Before further consideration is given to this application, we need the information requested on this form.

Title of License: License Number:

Original Issue Date: Expiration Date:

License Status: ❑Active ❑Inactive ❑Temporary ❑Delinquent ❑Other (Explain)

Licensure Method: ❑ Grandfathering ❑ Reciprocity/Endorsement ❑Examination

If licensed by examination, please complete the following:

Name of Exam: Date of Exam:

Level of Exam: Score Achieved:

Has any disciplinary action been taken against this license? ❑ YES ❑ NO

If "YES", please provide our office with any documentation regarding the disciplinary action.

Do you have any derogatory information concerning this person? ❑ YES ❑ NO

If "YES", please explain

Affix Board Seal	Signature:
	Title:
	Date:
	Phone Number:
	Board of:
	State of: