

Hearing Aid Specialist Application for Examination



**Board of Hearing Aid Specialists
P.O. Box 6330**

Tallahassee, FL 32314-6330

Website: www.floridashearingaidspecialists.gov

Email: info@floridashearingaidspecialists.gov

Phone: (850) 245-4292

Fax: (850) 413-6982





Are you an active duty member of the United States Armed Services?

Are you a veteran of the United States Armed Services?

Are you the spouse of a veteran of the United States Armed Services?

Are you the spouse of an active member of the United States Armed Services?

If you answered "Yes" to any of these questions, you may qualify for a reduction in your application fees. You can find information about the Florida Department of Health's commitment to serving members and veterans of the United States Armed Forces and their families online at

<http://www.flhealthsource.gov/valor>



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Do Not Write in this Space
For Revenue Receiving Only

Select only one method of application:

- Hearing Aid Specialist Licensure (3601)** **\$475.00**
For Nationally Certified Applicants ONLY
- Application for Licensure and Exam** **\$150.00** (Application Fee Only)
- Re-examination** **\$150.00** (Application Fee Only)

Total fee of \$475.00 includes the following:

Application Fee	\$150.00
Initial Licensure Fee	\$320.00
Unlicensed Activity Fee	\$5.00

Fees must be paid in the form of a cashier's check or money order, made payable to the Department of Health. An applicant who is denied licensure or withdraws their application is entitled to a \$325.00 (Initial Licensure Fee and Unlicensed Activity Fee) refund. **The \$150.00 Application Fee is non-refundable.** Requests to withdraw or for a refund must be made in writing. Fees are refundable for up to three years from the date of receipt.

1. PERSONAL INFORMATION

Name: _____ Date of Birth: _____
Last/Surname First Middle MM/DD/YYYY

Mailing Address: (The address where mail and your license should be sent)

Street/P.O. Box _____ Apt. No. City _____

State _____ ZIP _____ Country _____ Home/Cell Telephone (Input without dashes) _____

Practice Location: (Required if mailing address is a P.O. Box- This address will be posted on the Department of Health's website)

Street _____ Apt. No. City _____

State _____ ZIP _____ Country _____ Work/Cell Telephone (Input without dashes) _____

EQUAL OPPORTUNITY DATA:

We are required to ask that you furnish the following information as part of your voluntary compliance with Section 60-3, Uniform Guidelines on Employee Selection Procedure (1978) 43 CFR 38295 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.

Gender: Male Female
Race: Native Hawaiian or Pacific Islander American Indian or Alaska Native Two or More Races
 Hispanic or Latino Black or African American White Asian

Email Notification: To be notified of the status of your application by email, check the "Yes" box and fill in your email address on the line provided. If you choose to be notified via email you will be responsible for checking your email regularly and updating your email address with the board office.

Yes No Email Address: _____

Under Florida law, email addresses are public records. If you do not want your email address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.

2. SOCIAL SECURITY DISCLOSURE

This information is exempt from public records disclosure.

Pursuant to Title 42 United States Code § 666(a)(13), the department is required and authorized to collect Social Security numbers relating to applications for professional licensure. Additionally, section (s.) 456.013(1)(a), Florida Statutes (F.S.), authorizes the collection of Social Security numbers as part of the general licensing provisions.

Last Name: _____

First Name: _____

Middle Name: _____

Social Security Number: _____
(Input without dashes)

Social Security Information- * Under the Federal Privacy Act, disclosure of Social Security numbers is voluntary unless specifically required by federal statute. In this instance, Social Security numbers are mandatory pursuant to Title 42 United States Code § 653 and 654; and s. 456.013(1), 409.2577, and 409.2598, F.S. Social Security numbers are used to allow efficient screening of applicants and licensees by a Title IV-D child support agency to ensure compliance with child support obligations. Social Security numbers must also be recorded on all professional and occupational license applications and will be used for license identification pursuant to Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Welfare Reform Act. 104 Pub. L. Section 317). Clarification of the SSA process may be reviewed at www.ssa.gov or by calling 1-800-772-1213.

Name: _____

3. ELIGIBILITY DATA

Applicants for re-examination are not required to complete this section.

Indicate the method by which you qualify for hearing aid specialist examination/licensure. <u>Select only one:</u>	
<input type="checkbox"/> I. Current National Board Certification	<input type="checkbox"/> II. Florida Training Program
<input type="checkbox"/> III. Licensed in another state without National Board Certification	

Provide the requested information/documentation only in the section below that corresponds to the method by which you qualify.



I. Current National Board Certification – Requirements for licensure eligibility

A. Are you currently certified by the National Board for Certification in Hearing Instrument Sciences and actively practiced for 12 of the last 18 months? Yes No

If “No,” you are ineligible to apply by this method. If “Yes,” you must provide the following:

Proof of active practice: Submit **two contracts per month** for 12 of the last 18 months immediately preceding this application. The **applicant must be listed as the fitter and dispenser** of the hearing aid on the contracts/receipts. For privacy purposes, the client’s last name may be omitted on the contracts/receipts.

Proof of current certification: Contact the National Board for Certification in Hearing Instrument Sciences and request proof of current National Board Certification be sent directly to the board office.



II. Florida Training Program – Requirements for examination eligibility

A. Have you completed a Florida Hearing Aid Specialist Training Program, pursuant to Rule 64B6-8.003, Florida Administrative Code (F.A.C.)? Yes No

B. Trainee Registration Number: _____

Applicants who have completed a Florida Training Program must submit the two-page **Sponsor Report Form** found at the end of this application, **completed and signed by the approved sponsor.**



III. Licensed in another state without National Board Certification – Requirements for examination eligibility

A. Do you hold a valid, current license as a hearing aid specialist or equivalent in another state, and actively practiced in such capacity for at least 12 of the last 18 months? Yes No

If “No,” you are ineligible to apply by this method. If “Yes,” you must provide the following:

B. List the **active hearing aid specialist or equivalent license** from the state(s) in which you have actively practiced for 12 of the last 18 months.

License Type	License #	State/Country	Original Date Issued	Expiration Date	Status of License

Submit a License Verification form to each state in which you hold an **active license** as a hearing aid specialist or equivalent. License verifications must be received directly from the licensing authority. **A copy of your license will not be accepted** in lieu of official verification from the licensing agency.

Proof of active practice: Submit **two contracts per month** for 12 of the last 18 months immediately preceding this application. The **applicant must be listed as the fitter and dispenser** of the hearing aid on the contracts/receipts. For privacy purposes, the client’s last name may be omitted on the contracts/receipts.

Name: _____

Eligibility Information

Applicants without National Board Certification are required to sit for the International Hearing Society (IHS) examination. The application and all required supporting documentation must be received before the board can make a determination on eligibility for examination. Once determined eligible, applicants will receive an email from the IHS with instructions to create an account and schedule the examination. The IHS examination fee is \$225.00.

All eligibility documentation should be submitted to the board office at info@floridashearingaidspecialists.gov, or by mail to:

Board of Hearing Aid Specialists
4052 Bald Cypress Way Bin C-08
Tallahassee, FL 32399-3257

4. APPLICANT BACKGROUND

A. List any other name(s) by which you have been known in the past. Attach additional sheets if necessary.

B. Are you 18 years of age or older? Yes No

Proof of age: Submit a copy of either your **driver's license** or **birth certificate**.

C. Do you hold, or have you ever held a license to practice as a hearing aid specialist or any other health-related license(s)? Yes No

D. List all health-related licenses (active, inactive or lapsed), **unless provided on page 5**.

License Type	License #	State/Country	Original Date Issued	Expiration Date	Status of License

Submit a License Verification form to **ALL** state(s) of licensure. License verifications must be received directly from the licensing authority regardless of the status of the license. **A copy of your license will not be accepted** in lieu of official verification from the licensing agency.

E. 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

F. List all pending applications for licensure as a hearing aid specialist.

License Type	State/Country

Name: _____

5. DISASTER

Would you be willing to provide health services in special needs shelters or to help staff disaster medical assistance teams during times of emergency or major disaster? Yes No

6. EDUCATION HISTORY

A. Have you earned a high school diploma or equivalent? Yes No

B. Provide the following information about your high school or equivalent:

School Name	School Address	Graduation Date	Degree Awarded
			<input type="checkbox"/> Diploma <input type="checkbox"/> GED

Include a **photocopy of your high school diploma or equivalency certificate** as proof of graduation. A **college transcript** may also be accepted as proof.

C. Have you completed an approved two-hour Florida Laws and Rules course relating to the fitting and dispensing of hearing aids? Yes No

If you have not completed this course, you can find information on the course at www.cebroker.com.

Supporting documentation not submitted with the application must be sent to the board office at info@floridashearingaidspecialists.gov, or by mail to:

Board of Hearing Aid Specialists
4052 Bald Cypress Way Bin C-08
Tallahassee, FL 32399-3257

Name: _____

This information is exempt from public records disclosure.

7. HEALTH HISTORY

Physical and Mental Health Disorders Impacting Ability to Practice

- A. During the last two years, have you been treated for or had a recurrence of a diagnosed physical or mental disorder that impaired or would impair your ability to practice? Yes No
- B. In the last two years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental or physical disorder that impaired your ability to practice? Yes No

Substance-Related Disorders Impacting Ability to Practice

- C. During the last five years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol or drug) disorder that impaired or would impair your ability to practice? Yes No
- D. During the last five years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol or drug) disorder or, if you were previously in such a program, did you suffer a relapse? Yes No
- E. During the last five years, have you been enrolled in, required to enter, or participated in any substance-related (alcohol or drug) recovery program or impaired practitioner program for treatment of drug or alcohol abuse? Yes No

If a "Yes" response was provided to any of the questions in this section, provide the following documents directly to the board office:

- A letter from a Licensed Health Care Practitioner**, who is qualified by skill and training to address the condition identified, which explains the impact the condition may have on the ability to practice the profession with reasonable skill and safety. The letter must specify that the applicant is safe to practice the profession without restrictions or specifically indicate the restrictions that are necessary. Documentation provided must be dated within one year of the application date.
- A written self-explanation**, identifying the medical condition(s) or occurrence(s); and current status.

Name: _____

8. DISCIPLINE HISTORY

- A. 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
- B. Have you ever been denied the right to take a Hearing Aid Specialist licensure examination? Yes No
- C. Have you ever had a license to practice any profession revoked, suspended, or otherwise acted against in a disciplinary proceeding in any state? Yes No
- D. 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
- E. Is there currently pending, in any jurisdiction, a complaint or investigation against your professional conduct or competency? Yes No

If you responded "Yes" to any of the questions in this section, complete the following:

Name of Agency	State	Action Date: MM/DD/YYYY	Final Action	Under Appeal?
				<input type="checkbox"/> Y <input type="checkbox"/> N
				<input type="checkbox"/> Y <input type="checkbox"/> N
				<input type="checkbox"/> Y <input type="checkbox"/> N
				<input type="checkbox"/> Y <input type="checkbox"/> N

If you responded "Yes" to any of the questions in this section, you must provide the following:

- A written self-explanation**, describing in detail the circumstances surrounding the disciplinary action.
- A copy of the **Administrative Complaint** and **Final Order**.

9. CRIMINAL HISTORY

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. Yes No

Reckless driving, driving while license suspended or revoked (DWSLR), driving under the influence (DUI) or driving while impaired (DWI) are not minor traffic offenses for purposes of this question.

If you responded "Yes," complete the following:

Offense	Jurisdiction	Date: MM/DD/YYYY	Final Disposition	Under Appeal?
				<input type="checkbox"/> Y <input type="checkbox"/> N
				<input type="checkbox"/> Y <input type="checkbox"/> N
				<input type="checkbox"/> Y <input type="checkbox"/> N

If you responded "Yes" in this section, you must provide the following:

- A written self-explanation**, describing in detail the circumstances surrounding each offense; including dates, city and state, charges and final results.
- Final Dispositions** and **Arrest Records** for all offenses. The Clerk of the Court in the arresting jurisdiction will provide you with these documents. Unavailability of these documents must come in the form of a letter from the Clerk of the Court.
- Completion of Sentence Documents**. You may obtain documents from the Department of Corrections. The report must include the start date, end date, and that the conditions were met.

Name: _____

10. CRIMINAL AND MEDICAID/MEDICARE FRAUD QUESTIONS

IMPORTANT NOTICE: Applicants for licensure, certification, or registration and candidates for examination may be excluded from licensure, certification, or registration if their felony convictions fall into certain timeframes as established in s. 456.0635(2), F.S.

1. Have you been convicted of, or entered a plea of guilty or nolo contendere, regardless of adjudication, to a felony under chapter (ch.) 409, F.S. (relating to social and economic assistance), ch. 817, F.S. (relating to fraudulent practices), ch. 893, F.S. (relating to drug abuse prevention and control), or a similar felony offense(s) in another state or jurisdiction? Yes No

If you responded "No" to the question above, skip to question 2.

- 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 ten years from the date of the plea, sentence, and completion of subsequent probation (this question does not apply to felonies of the third degree under s. 893.13(6)(a), F.S.)? Yes No
- c. If "Yes" to 1, for the felonies of the third degree under s. 893.13(6)(a), F.S., has it been more than five 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, to a felony under 21 U.S.C. ss. 801-970 or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)? Yes No

If you responded "No" to the question above, skip to question 3.

- 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 s. 409.913, F.S.? Yes No

If you responded "No" to the question above, skip to question 4.

- 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

Name: _____

4. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program? Yes No

If you responded "No" to the question above, skip to question 5.

- a. Have you been in good standing with a state Medicaid program for the most recent five years?
 Yes No
- b. Did termination occur at least 20 years before the date of this application? Yes No
5. Is the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant currently listed on the United States Department of Health and Human Services' Office of the Inspector General's List of Excluded Individuals and Entities (LEIE)? Yes No
- a. If "Yes" to 5, is the applicant, principal, officer, agent, managing employee, or affiliated person of the applicant listed because the individual defaulted or is delinquent on a student loan? Yes No
- b. If "Yes" to 5.a., is the student loan default or delinquency the only reason the individual is listed on the LEIE? Yes No

If you responded "Yes" to any of the questions in this section, you must provide the following:

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.

Supporting documentation including court dispositions or agency orders where applicable.

Documentation for sections 7, 8, 9, and 10 must be sent to the board office at info@floridashearingaidsspecialists.gov, or mailed to:

Board of Hearing Aid Specialists
4052 Bald Cypress Way Bin C-08
Tallahassee, FL 32399-3257

If you have a disability and require special examination accommodations, you must contact the International Hearing Society immediately at (734) 522-7200.

Name: _____

11. APPLICANT SIGNATURE

I, the undersigned, state that I am the person identified in this application for licensure in the state of Florida.

I recognize that providing false information may result in disciplinary action against my license or criminal penalties pursuant to s. 456.067 and 775.083, F.S.

Florida law requires me to immediately inform the board of any material change in any circumstances or condition stated in the application which takes place between the initial filing and the final granting or denial of the license and to supplement the information on this application as needed.

I hereby acknowledge that I have read the regulations in ch. 484, Part II, F.S. and ch. 64B6, F.A.C. I understand that I am under a continuing obligation to keep informed of any changes to ch. 456 and 484, Part II, F.S. and ch. 64B-6, F.A.C.

Section 456.013(1)(a), F.S., provides that an incomplete application shall expire one year after the initial filing with the department.

Applicant Signature _____ Date _____
You may print this application and sign it or sign digitally. MM/DD/YYYY

4. TRAINING INFORMATION

Program dates: From: _____ To: _____
 MM/DD/YYYY MM/DD/YYYY

Total number of training weeks completed: _____

Check the type of training received during this program and the number of training hours received, pursuant to Rule 64B6-8.003(3), F.A.C.

✓	Required Training Subject Areas	# of Training Hours
	Part II, ch. 484, F.S. and Rule ch. 64B6, F.A.C.	
	Physics of Sound	
	Anatomy of the Outer, Middle and Inner Ear	
	Hearing Disorders:	
	Conductive Hearing Loss: Diseases of the Ear	
	Sensori-Neural Hearing Loss	
	Mixed Hearing Loss	
	Central Deafness Hearing Loss	
	Psychological Hearing Loss	
	Criteria for Medical Referral	
	Pure Tone Audiometry	
	Masking and its Application when utilized with Pure Tone Audiometry: Rationals; Methods; Techniques	
	Speech Audiometry	
	Masking and its Application when utilized with Speech Audiometry	
	Sound Field Testing	
	Audiogram Analysis and Interpretation	
	Proper Ear/Ears Selection; Hearing Instrument Selection:(Evaluating Fitting Criteria)	
	Cros/Bi-Cros: Rationale and its Application	
	Hearing Aid Measurements	
	Interpretation of Hearing Instruments Specification Data	
	Impression Technique	
	Earnolds; Shell Design; and their Effect on Frequency Response	
	Types of Hearing Instruments; Major Components; Function	
	Clients Counseling and Delivery as it pertains to Hearing Aid usage and care for optimum performance	

Trainee Name: _____ Trainee Program Number: _____

Trainee Signature: _____ Date: _____
 MM/DD/YYYY

Sponsor Name: _____ Sponsor License Number: _____

Sponsor Signature: _____ Date: _____
 MM/DD/YYYY

Complete verifications must be mailed directly from the licensing agency to:

Board of Hearing Aid Specialists
4052 Bald Cypress Way Bin C-08
Tallahassee, FL 32399-3257



Board of Hearing Aid Specialists License/Certification Verification Request

Part I: To be completed by applicant (Florida requires verification of all your current and previously held licenses.)

Name: _____

Address: _____

Name original license was issued under: _____

License Number: _____ State: _____

I hereby authorize release of any information regarding my licensure status to the Florida Board of Hearing Aid Specialists.

Applicant Signature: _____ Date: _____
MM/DD/YYYY

Part II: To be completed by state licensing agency

All verifications must be in English and include the following criteria:

- * Typed on an official state form or letterhead
- * Include an official board seal
- * Signature and title of state board official

The following information must be included in all verifications:

- * Licensee name
- * Licensure status
- * Date of issuance/expiration
- * Licensure method (examination, grandfathering, reciprocity/endorsement) If exam, provide exam name, exam level, exam date and score achieved.
- * Has this license ever been encumbered (denied, revoked, suspended, surrendered, limited, placed on probation)?
- * If this license has ever been encumbered, please provide certified copies of documentation regarding the action with the completed license verification.
- * License number
- * Is license in good standing?
- * State or jurisdiction of licensure