Hearing Aid Specialist Application for Examination

Board of Hearing Aid Specialists
P.O. Box 6330
Tallahassee, FL 32314-6330
Website: www.floridashearingaidspecialists.gov
Email: MQA.HearingAid@flhealth.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.

Florida HEALTH Medical Quality Assurance

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Do Not Write in this Space
For Revenue Receipting Only

Select only **one** method of application (3601):

Hearing Aid Specialist Licensure (1021) **$475.00**
For applicants who are NBC-HIS Board-Certified or who have already passed the International Licensing Examination (ILE) in another state

Total fee of $475.00 includes the following:

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

Application for Licensure and Exam (1010) **$150.00** (Application Fee Only)

Re-examination (1011) **$150.00** (Application Fee Only)

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

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

EQUAL OPPORTUNITY DATA:

We are required to ask that you furnish the following information as part of your voluntary compliance with 41 CFR Part 60-3-Uniform Guidelines on Employee Selection Procedure (1978); 43 FR 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, authorizes the collection of Social Security numbers as part of the general licensing provisions.

Last Name: ____

First Name: ____

Middle Name: ____

U.S. Social Security Number: ____

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, Florida Statutes. 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. Select only one:	
I. NBC-HIS Board Certification or passed the ILE	**II.** Florida Training Program
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. NBC-HIS Board Certification or passed the ILE – *Requirements for licensure eligibility*

A. Are you currently NBC-HIS Board-Certified or have you already passed the ILE for Hearing Healthcare Professionals in another state, **and** have actively practiced for 12 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 at least 12 months during which you were actively practicing as a hearing aid specialist or its equivalent. The applicant must provide at least **two sales receipts per month** with each receipt bearing the applicant's signature and address of place(s) of business. 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 NBC-HIS 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 NBC-HIS 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 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 at least 12 months.

License Type	License #	State/Country	Original Date Issued (MM/DD/YYYY)	Expiration Date (MM/DD/YYYY)	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 at least 12 months during which you were actively practicing as a hearing aid specialist or its equivalent. The applicant must provide at least **two sales receipts per month** with each receipt bearing the applicant's signature and address of place(s) of business. 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 MQA.HearingAid@flhealth.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 (MM/DD/YYYY)	Expiration Date (MM/DD/YYYY)	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. AVAILABILITY FOR 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

If you respond “Yes,” your name will be added to a listing that is available to the Department of Health if a disaster is declared. If you live in an area where you may be able to help you will be called on if needed.

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 (MM/DD/YYYY)	Degree Awarded
			Diploma GED

Include a **photocopy of your high school diploma or equivalency certificate** as proof of graduation. A **college transcript of a completed associate or higher degree** 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 prescription 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 via the online upload system at https://mqaonline.doh.state.fl.us/datamart/voservicesportal/, email to MQA.HearingAid@flhealth.gov, or by mail to:

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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 prescription 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?
				Y N
				Y N
				Y N
				Y 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.

Reckless driving, driving while license suspended or revoked (DWLSR), driving under the influence (DUI) or driving while impaired (DWI) are not minor traffic offenses for purposes of this question. Yes No

If you responded "Yes," complete the following:

Offense	Jurisdiction	Date (MM/DD/YYYY)	Final Disposition	Under Appeal?
				Y N
				Y N
				Y 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), Florida Statutes.

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, Florida Statutes (relating to social and economic assistance), ch. 817, Florida Statutes (relating to fraudulent practices), ch. 893, Florida Statutes (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 10 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), Florida Statutes)? Yes No

c. If "Yes" to 1, for the felonies of the third degree under s. 893.13(6)(a), Florida Statutes, 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," 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, Florida Statutes? 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

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

Name: ____

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 via the online upload system at https://mqaonline.doh.state.fl.us/datamart/voservicesportal/, email to MQA.HearingAid@flhealth.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.

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, Florida Statutes.

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, Florida Statutes 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, Florida Statutes, and ch. 64B6, F.A.C.

Section 456.013(1)(a), Florida Statutes, 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

Complete forms must be submitted directly by the sponsor through email at MQA.HearingAid@flhealth.gov, fax at (850) 413-6982, or mail at:

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

Board *of* Hearing Aid Specialists
Training Program Sponsor Report Form

Page 1 of 2

Sponsor must complete and submit both pages of this form

Pursuant to Rule 64B6-8, F.A.C., the sponsor must complete and mail this form to the board office within 30 days after the end of the reporting period or date of termination. Until the board has received this form, the trainee will not receive credit for weeks worked, or be allowed to sit for the examination.

Select report type:
If the trainee is transferring to another sponsor, this falls under termination.

Final Report   Termination Report

If applicable, provide the date the supervision of trainee was terminated or will terminate: ____________________
MM/DD/YYYY

1. TRAINEE INFORMATION

Name: ____

Address: ____
Street and Number   City   State   ZIP

Is address new?   Yes   No

Work Telephone Number: ______________________ Trainee Program Number: ______________

2. REPORTING/TERMINATING SPONSOR INFORMATION

Sponsor Name: ____

Business Address: ____
Street and Number   City   State   ZIP

Telephone Number: ______________________ Sponsor License Number: ______________

3. TRAINING OBJECTIVES

A. List the educational and training objectives, pursuant to Rule 64B6-8.003(3), Florida Administrative Code (F.A.C.):

____

____

B. List hours set by the sponsor for the trainee, pursuant to Rule 64B6-8.003(3), F.A.C.:

____

Name: ____

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, Florida Statutes, 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	
	Sensorineural 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: Rationales; 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	
	Prescription Hearing Aid Measurements	
	Interpretation of Hearing Instruments Specification Data	
	Impression Technique	
	Earmolds; Shell Design; and their Effect on Frequency Response	
	Types of Hearing Instruments; Major Components; Function	
	Clients Counseling and Delivery as it pertains to prescription 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 submitted directly from the licensing agency through email at MQA.HearingAid@flhealth.gov, fax at (850) 413-6982, or mail at:

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 a 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
* License number
* State or jurisdiction of licensure
* Licensure status
* Is license in good standing?
* 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.