Hearing Aid Specialist Application for Training Program Registration

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

DH-MQA 1158, Revised 7/2023, Rule 64B6-8.002, F.A.C.

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Do Not Write in this Space
For Revenue Receipting Only

Training Program Registration **$105.00**

Total fee of $105.00 includes the following:	
Application Fee	$100.00
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. The application fee is non-refundable.

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

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

_____ _____ _____
Street (Place of Employment) Suite 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.

3. APPLICANT BACKGROUND

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

_____

B. 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

C. List all health-related licenses (active, inactive, or lapsed).

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.

D. 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.

License Type	State/U.S. Territory/Country

4. SPONSOR INFORMATION

An applicant must secure the supervision of a sponsor who:

- must have an active hearing aid specialist license,
- has been actively practicing for at least two consecutive years immediately prior to sponsorship,
- and who must not have been disciplined during the past four years.

☐ **The sponsor must submit official documentation of being board certified by the National Board for Certification in Hearing Instrument Sciences with each application. Sponsors may have a <u>maximum</u> of three trainees.**

The sponsor may designate a hearing aid specialist with an active Florida license to assist in training. The designated person must have possessed an active hearing aid specialist license and have been actively practicing for at least two consecutive years immediately prior to being designated to assist in a training program and who must not have been disciplined during the past four years.

☐ **The designated hearing aid specialist 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.

Name: _____

Primary Sponsor Name_____

Address_____

License Number_____ ☐ I have attached a copy of my current NBC/HIS certification.

Designated Hearing
Aid Specialist Name_____

Address_____

License Number_____ ☐ I have attached a copy of my current NBC/HIS certification.

5. TRAINING PROGRAM STAGES

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

Stage	Timeframe	Description
I	**-**	During this stage, the trainee is required to complete the International Hearing Society Home Study Course and must submit proof of passing the home study course final examination **before beginning work**.
II	**1 month**	During this stage, the trainee may perform audiometric tests, and make ear 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 prescription hearing aid, dispense a prescription hearing aid, or counsel a client.
III	**2 months**	During this stage the trainee may perform all tasks in Stage II, recommend the selection of a prescription hearing aid, and counsel a client, but the trainee shall be under the direct supervision of the sponsor or hearing aid specialist designed by the sponsor. The trainee may not deliver a prescription hearing aid.
IV	**3 months**	During this stage the trainee may perform all the tasks in Stage II and III and deliver prescription 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 prescription hearing aid is delivered to the client, and the receipt required by s. 484.01, Florida Statutes, must have the signature and licensure number of the sponsor or hearing aid specialist designated by the sponsor.

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

This information is exempt from public records disclosure.

6. 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.

7. 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**.

8. 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: _____

9. 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

5. Are you 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 you responded "Yes" to the question above, are you listed because you defaulted or are delinquent on a student loan? ☐ Yes ☐ No

   b. If you responded "Yes" to question 5.a., is the student loan default or delinquency the only reason you are 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 self-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 6, 7, 8, and 9 must be mailed to:

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

10. APPLICANT SIGNATURE

I, the undersigned, state that I am the person referred to 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 practice as a licensed Hearing Aid Specialist in Florida is governed by ch. 456 and, Part II, Florida Statutes, and ch. 64B6, Florida Administrative Codes (F.A.C.). I understand that I am under a continuing obligation to understand and keep informed of any changes to ch. 456 and 484, Part II, Florida Statutes, and ch. 64B6, F.A.C. 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.

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 out the application and sign it or sign digitally. MM/DD/YYYY

Complete registration forms must be submitted 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
Sponsor Registration Form

- To be completed and submitted by the new sponsor before the trainee begins work under new sponsorship.
- The trainee will not receive credit for hours worked under the new sponsor until the board has received this form, NBCHIS verification, and approved the sponsor.
- Refer to Rule 64B6-8, Florida Administrative Code (F.A.C.)

Is this a Change of Sponsor? Yes No

If "Yes," provide the Trainee's AT #: _____

Trainee Name: _____ Trainee Date of Birth: _____
MM/DD/YYYY

Sponsor Name: _____ Sponsor License #: _____

Designee Name: _____ Designee License #: _____
(if applicable)

Business Name: _____

Business Telephone: _____

Training Site Address: _____
Street and Number City State ZIP

List names of any additional trainees currently under your supervision:

Sponsors may have a maximum of three trainees.

1. _____ 2. _____

I, the undersigned, confirm 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 within the past four years; and I understand my responsibilities and the limitations of being a sponsor for a Training Program, pursuant to chapter 484, Part II, Florida Statutes, and Rule 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 confirm that all statements made above are true and correct and that I have enclosed proof of National Certification.

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

Designee Signature: _____ Date: _____
(if applicable) MM/DD/YYYY

Complete forms must be submitted 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

Sponsor must complete and submit both pages of this form

Pursuant to Rule 64B6-8, Florida Administrative Code (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), 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, chapter 484, Florida Statutes, and Rule 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	
	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:

Florida 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
* 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 name of exam, level of exam, date of exam, 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.