BOARD OF HEARING AID SPECIALISTS
STATE OF FLORIDA
EXAMINATION APPLICATION FOR LICENSURE

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 18 years of age or older - Please submit a copy of your driver's license or birth certificate.
- Proof of graduation from an accredited high school or its equivalent – please send proof of high school diploma. A college transcript can be submitted for proof.
- Has met one of the following:
    1. Has met the requirements of the training program – please submit the 2 page sponsor final report form; or
    2. a. Has a valid, current license as a hearing aid specialist or its equivalent from another state and has been actively practicing in such capacity for at least 12 months; or
       b. Is currently certified by the National Board for Certification in Hearing Instrument Sciences and has been actively practicing for at least 12 months;

Documentation must be submitted to verify you have actively practiced for 12 of the last 18 months, pursuant to Rule 64B6-2.002(1).

- 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 use the form attached or have each agency mail a verification of licensure directly to this office.
- Proof of a board approved two-hour course in state laws and rules relating to the fitting and dispensing of hearing aids.

APPLICATION AND CREDENTIALS

The application and supporting documentation must be received before an eligibility determination can be made. Once you are determined eligible to sit for the examination, the International Hearing Society will send you an email message to create an account and instructions on how to schedule your examination using webassessor.

APPLICATION INSTRUCTIONS

I. FEES

Attach a check or money order payable to the Department of Health. Do not submit cash with the application.

REQUIRED FEES FOR APPLICANTS NOT NATIONALLY CERTIFIED:

Submit with this application a check or money order in the amount of $150.00 made payable to the Department of Health for the application fee. The application fee is nonrefundable.

Once the Board determines your eligibility for the examination, the International Hearing Society will send you an email message to create an account and instructions on how to schedule your examination using webassessor. The IHS examination fee is $225.00. The IHS examination is a computer based test that will assist the state licensing body in the responsibility to identify professionals whose knowledge and clinical skills meet or exceed basic expected professional standards.

REQUIRED FEES FOR APPLICANTS THAT ARE NATIONALLY CERTIFIED:

The initial licensure fee is subject to change according to the date you apply for licensure. Submit a check or money order made payable to the Department of Health in the amount applicable in the chart below. The fees below include an application fee of $150.00, which is nonrefundable. The initial licensure fee is $320.00. In addition, by statute there is a special fee of $5.00 per license to fund efforts to combat unlicensed activity. You will not be required to sit for the examination upon receipt of proof that you are nationally certified.

Application Fee:	$150.00
Initial Licensure Fee:	$320.00
Unlicensed Activity Fee:	$5.00
TOTAL FEE:	**$475.00**

MAIL APPLICATION PACKET AND FEE TO:

BOARD OF HEARING AID SPECIALISTS
PO BOX 6330
TALLAHASSEE, FLORIDA 32314-6330

CORRESPONDENCE BEING MAILED SEPARATE FROM THE APPLICATION
MAIL TO:

BOARD OF HEARING AID SPECIALISTS
4052 BALD CYPRESS WAY, BIN C08
TALLAHASSEE, FLORIDA 32399-3258

COMPLETING THE APPLICATION AND FORMS

Original forms must be submitted, photocopies of signatures will not be accepted unless specified. Complete all forms by printing neatly in black ballpoint pen or typing all information.

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. It is your responsibility to notify this office in writing if the answers to any of these questions change.

1. APPLICATION CATEGORY: Complete section one by checking the appropriate box. If this application is for your first hearing aid specialists examination, check the box for "original application." If you are retaking the examination, check the "re-examination" box and list the date(s) of the previous hearing aid specialists examination(s) you have taken. If you are nationally certified, check the box indicating "nationally certified." (Upon submission of documentation verifying national certification, that applicant will not be required to sit for the examination.)

2. APPLICANT PROFILE DATA: Print neatly in black ballpoint pen or type all information. It is very important that you provide us with an e-mail address so you can receive eligibility updates and instructions on how to schedule your examination.

3. ELIGIBILITY DATA: Indicate the method by which you qualify for examination or licensure.

- **Completed Training Program** – Please provide your trainee registration number. A Trainee is required to take the first available examination after completion of the training program. Your sponsor must submit the "2 page Training Program Sponsor Report Form." However, you still must submit this Hearing Aid Specialists Licensure by Examination application, and meet the eligibility requirements to receive scheduling information for the examination.
- **Current Licensure in Another State and Actively Practicing in Another State for 12 of the last 18 Months** - Documentation must be submitted to verify you have actively practiced for 12 of the last 18 months pursuant to Rule 64B6-2.002(1). A License/Certification Verification must be submitted from each state in which you hold or ever held a license. This verification must be mailed directly to this office from each state or it will not be considered official.
- **Currently Certified by the National Board for Certification in Hearing Instrument Sciences (NBCHIS) and Actively Practiced for 12 of the last 18 Months** – You must contact the NBCHIS and request they send proof of National Board Certification directly to the Board of Hearing Aid Specialists' board office. Documentation must be submitted to verify you have actively practiced for 12 of the last 18 months pursuant to Rule 64B6-2.002(1).

4. ACCREDITED HIGH SCHOOL: Please send proof of high school diploma. A college transcript can be submitted for proof.

5. SPECIAL TESTING ACCOMMODATIONS: If you have a disability and require special examination accommodations, you must contact the International Hearing Society at (734) 522-7200. Please contact them immediately.

6. 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.

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

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

9. 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.

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

11. SOCIAL SECURITY NUMBER: Your social security number is required.

12. APPLICANT HISTORY - HEALTH: The board reviews each applicant's history to determine that the applicant is able to practice 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.

DH-MQA 1155

APPLICATION FOR HEARING AID SPECIALIST LICENSURE BY EXAMINATION

DO NOT WRITE IN THIS SPACE
FOR OFFICE USE ONLY

1. APPLICATION CATEGORY *(PLEASE TYPE OR PRINT IN BLACK INK)*

Please check one: **CLIENT 3601**

❑ Original Application ❑ Nationally Certified

❑ Re-examination/date(s) of previous exam(s) taken _____

_____

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

Name	Last	First	Middle	E-mail Address
Mailing Address	No. and Street.		Apt. No.	Home Telephone: ( )
	City	State	Zip	Business Telephone: ( )
Location Address	No. and Street.			Date of Birth: _____/_____/_____
	City	State	Zip	

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: _____

_____

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

3. ELIGIBILITY DATA (If this is a re-examination application, you are not required to complete this section.)

Indicate the method by which you qualify for the Hearing Aid Specialist Examination/Licensure:

❑ Completed the Training Program / Trainee Registration Number _____

❑ Current licensure in another state and actively practiced for 12 of the last 18 months.

❑ Currently certified by the National Board for Certification in Hearing Instrument Sciences and actively practiced for 12 of the last 18 months.

4. ACCREDITED HIGH SCHOOL Please provide name and address of the accredited high school attended:

_____

Received: ❑ Diploma ❑ GED Date of Receipt _____

5. SPECIAL TESTING ACCOMMODATIONS

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

APPLICANT NAME _____

6.	**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 or conviction, and completion of any sentence or subsequent period of 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

7. 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 notified to appear before any licensing agency for a hearing on a complaint of any nature, including, but not limited to, a charge of violation of a practice act, unprofessional or unethical conduct?	☐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 8, you must provide the Board complete details.	

8. APPLICANT HISTORY – GENERAL	
1. Have you ever been convicted of, or entered a plea of guilty or nolo contendere (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.	☐Yes ☐No
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.	

APPLICANT NAME _____

9. 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:

10. 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 instrumentalities (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 Sections 456.072, F.S. and 456.013(1)(2) 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 I have read the regulations in Chapter 484, Part II, Florida Statutes and Chapter 64B6, Florida Administrative Code. I understand that I am under a continuing obligation to keep informed of any changes to Chapters 456 and 484, Part II, Florida Statutes and Chapter 64B-6, Florida Administrative Code.

I understand that pursuant to Section 456.013(1)(a), Florida Statute, an incomplete application shall expire one (1) year after initial filing.

_____ _____

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), and 456.013(12), Florida Statutes.

Name: _____

Last **First** **Middle**

11. Social Security Number: _____ - _____ - _____

12. APPLICANT HISTORY – HEALTH
If you answer "YES" to any of the following questions, you 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

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: