Reset a Form

APPLICATION FOR A STUDENT HEARING AID DEALER CERTIFICATE

State Form 50686 (R7 / 2-14)

Approved by State Board of Accounts, 2013

COMMITTEE OF HEARING AID DEALER EXAMINERS
PROFESSIONAL LICENSING AGENCY
402 West Washington Street, Room 072
Indianapolis, Indiana 46204
Telephone: (317) 234-2067
E-mail: pla4@pla.IN.gov

* Your Social Security number is being requested by this state agency in accordance with I.C. 25-1-5-11. Disclosure is mandatory and the record cannot be processed without it.

FOR OFFICE USE ONLY	
APPLICATION FEE	
DATE FEE PAID *(month, day, year)*	
RECEIPT NUMBER	
CERTIFICATE NUMBER	
LICENSE ISSUED DATE *(month, day, year)*	

APPLICANT

Attach one (1) passport type quality photograph of yourself taken within the last eight (8) weeks. Please sign photograph at the bottom. Negative and Polaroids are not acceptable.

DO NOT WRITE ABOVE THIS LINE

APPLICANT INFORMATION		
Name of applicant (*last, first, middle*)		Social Security number*
Address (*number and street or rural route, city, state, and ZIP code*)		
Daytime telephone number ( )	Evening telephone number ( )	E-mail address
Date of birth *(month, day, year)*		Place of birth

HIGH SCHOOL DIPLOMA, EQUIVALENCY CERTIFICATE OR STATE OF INDIANA GENERAL EDUCATIONAL DEVELOPMENT (GED) DIPLOMA GRANTED BY:		
NAME OF SCHOOL	LOCATION OF SCHOOL	DATE OF GRADUATION *(month, day, year)*

STUDENT HEARING AID DEALER CERTIFICATE(S) LIST YOUR CURRENT AND PAST STUDENT HEARING AID DEALER CERTIFICATE(S)		
CERTIFICATE NUMBER	SPONSOR	DATES HELD *(month, day, year)*

LIST ALL DATES YOU HAVE PREVIOUSLY TAKEN THE HEARING AID DEALER EXAMINATION.

LIST ALL STATES, INCLUDING INDIANA, IN WHICH THE APPLICANT HAS EVER APPLIED FOR, OR HELD, A CERTIFICATE TO PRACTICE AS A HEARING AID DEALER

TYPE OF LICENSE / CERTIFICATE	NUMBER	DATE ISSUED *(month, day, year)*	CURRENT STATUS

If your answer is "Yes" to any of the following, expain fully in a signed and notarized statement, including all related details. Including the violation, location, date and disposition. If malpractice, provide name(s) of plaintiff(s). Letters from attorneys or insurance companies are not accepted in lieu of your statement. Falsification of any of the following is grounds for permanent revocation of a license or permit issued pursuant to this application.

1. Has disciplinary action ever been taken regarding any health license, certificate, registration or permit that you hold or have held? ☐ Yes ☐ No
2. Have you ever been denied a license, certificate, registration or permit to practice any regulated health occupation in any state *(including Indiana)* or country? ☐ Yes ☐ No
3. Do you have any condition or impairment *(including a history of alcohol or substance abuse)* that currently interferes, or if left untreated may interfere, with your ability to practice in a competent and professional manner? ☐ Yes ☐ No
4. *Except for minor violations of traffic laws resulting in fines, and arrests or convictions that have been expunged by a court,*
   (1) have you ever been arrested;
   (2) have you ever entered into a prosecutorial diversion or deferment agreement regarding any offense, misdemeanor, or felony in any state;
   (3) have you ever been convicted of any offense, misdemeanor, or felony in any state;
   (4) have you ever pled guilty to any offense, misdemeanor, or felony in any state; or
   (5) have you ever pled *nolo contendre* to any offense, misdemeanor, or felony in any state?
   ☐ Yes ☐ No
5. Have you ever been denied staff membership or privileges in any hospital or health care facility or had such membership or privileges revoked, suspended or subjected to any restrictions, probation or other type of discipline or limitations? ☐ Yes ☐ No
6. Have you ever been admonished, censured, reprimanded or requested to withdraw, resign or retire from any hospital or health care facility in which you have trained, held staff membership or privileges or acted as a consultant? ☐ Yes ☐ No
7. Have you ever had a malpractice judgment against you or settled any malpractice action? ☐ Yes ☐ No

APPLICATION AFFIRMATION

I hereby swear or affirm, under the penalties of perjury, that the statements made in this application are true, complete and correct.

Signature of applicant	Date *(month, day, year)*

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize, request and direct any person, firm, officer, corporation, association, organization or institution to release to the Professional Licensing Agency, or Committee of Hearing Aid Dealer Examiners, any files, documents, records or other information pertaining to the undersigned requested by the Agency, or the Committee, or any of their authorized representatives in connection with processing my application for licensure.

I hereby release the aforementioned persons, firms, officers, corporations, associations, organizations and institutions from any liability with regard to such inspection or furnishing of any such information.

I further authorize the Professional Licensing Agency, or the Committee of Hearing Aid Dealer Examiners, to disclose to the aforementioned persons, firms, officers, corporations, associations, organizations, and institutions any information which is material to my application, and I hereby specifically release the Agency, and the Committee from any and all liability in connection with such disclosures.

A photostatic copy of this authorization has the same force and effect as the original.

AFFIRMATION

I hereby swear or affirm, that I have read the above statements and agree to same.

Signature of applicant	Date (*month, day, year*)

TO BE COMPLETED BY THE REGISTERED HEARING AID DEALER SPONSOR AND STUDENT HEARING AID DEALER

BEFORE A CERTIFICATE OF STUDENT REGISTRATION CAN BE ISSUED, THIS FORM MUST BE COMPLETED AND SIGNED BY THE SPONSORING HEARING AID DEALER AND THE STUDENT HEARING AID DEALER.

Name of registered hearing aid dealer sponsor (*last, first, middle, maiden*)	List other names you have used:
Name of business	
Business address (*number and street, city, state, and ZIP code*)	Registration number
Business telephone number ( )	E-mail address
Name of student hearing aid dealer you will be sponsoring:	

List all student hearing aid dealers you are sponsoring at this time:

NAME	SHAD NUMBER	EXPIRATION DATE *(month, day, year)*

ACCORDING TO 844 IAC 9-3-2(2) BOTH PARTIES MUST READ AND SIGN THAT THEY UNDERSTAND THE STUDENT / SPONSOR RELATIONSHIP AS SET FORTH IN 844 IAC 9-6-1.

844 IAC 9-6-1 SUPERVISION OF STUDENT HEARING AID DEALERS

(a) Supervision means the direct and regular observation and instruction of the student hearing aid dealer by the sponsoring hearing aid dealer and that the sponsor and student shall be present in the same work setting. All tests and fittings performed by the student shall be personally monitored by the sponsor. The student shall meet at least once each working day with the sponsor to review all work performed by the student. This meeting must include the actual presence of the student and sponsor.

(b) It shall be the joint responsibility of the student and sponsor to see that all testing and sales documents pertinent to each sale, whether or not the sale was consummated, are submitted to and reviewed by the sponsor for the term of the student certificate.

(c) The committee may require a student or sponsor to show proof of the student's training and / or the sponsor's supervision.

(d) A student hearing aid dealer shall clearly identify himself / herself as a student when performing his / her duties.

(e) A student shall prominently display his / her certificate of registration as a student hearing aid dealer in the primary location of his / her employment.

(f) Any violation of these requirements and standards shall subject the student and sponsor to disciplinary action as provided in IC 25-1-9.

AFFIRMATION

I hereby swear or affirm that I have read the above statements and agree to same.

Signature of registered hearing aid dealer	Date (*month, day, year*)
Signature of student hearing aid dealer	Date (*month, day, year*)