



Minnesota Department of Health
 Health Occupations Program
 PO Box 64882
 Saint Paul MN 55164-0882

FOR MDH USE ONLY	
Approved:	_____
Denied:	_____
Trainee Exp:	_____
Check # _____	Amt \$ _____

HEARING INSTRUMENT DISPENSER TRAINEE APPLICATION

MINNESOTA GOVERNMENT DATA PRACTICES ACT NOTICE: The information requested on this form will be used only by Health Department Staff to determine whether the applicant and the supervisor meet the requirements of Minn. Stat. §153A.14, Subdivision 4a or 4c. All information, except your name and address, provided by you on this form are considered private until this application is approved, at which point all information becomes public. Failure to provide the requested information may delay the application and approval, and providing false or misleading information on this form is grounds for denial of this trainee application, for denial of certification as a hearing instrument dispenser, and for an enforcement action authorized by Minnesota Statutes §153A.15, Subdivision 2.

INSTRUCTIONS: Complete the front page of this form and obtain the signature of a certified dispenser who will be your supervisor. The supervisor must complete the back page of this form. When complete, mail this form with the trainee fee to the Health Occupations Program at the above address. You must **receive written approval from the Minnesota Department of Health** before dispensing hearing instruments as a trainee.

TRAINEE APPLICATION FEE: \$200.00. Make checks payable to: Treasurer, State of Minnesota.

ALL FEES ARE NONREFUNDABLE

Please Print:

Trainee Applicant: _____

Last Name First Name M.I.

Home Address: _____ Home phone:(____)_____

Street

City State Zip

Business Name and Address,
 If approved as a trainee: _____

Name of Business Street

Business phone:(____)_____

City State Zip

e-mail address _____

Social Security Number: _____
 (This information is required by Minn. Stat. sec. 270C.72, Subd. 4.)

Birth Date: _____ (Applicants must be at least 21 years of age)

TRAINEE-APPLICANT AFFIRMATION: I hereby make application as a trainee to dispense hearing instruments in Minnesota. I understand that as a trainee I must dispense hearing aids under direct supervision of a certified dispenser who dispenses until I have taken and passed the practical examination. Thereafter, I may dispense hearing instruments under indirect supervision until I am certified or until the expiration date of my trainee period. The trainee period automatically expires two months following notice of my passing all examination requirements. I will use the supervisor's credential number on all contracts for sale of hearing instruments. By signing below, I certify that: 1) I have read and will comply with the requirements of Minn. Stat. §153A.14, Subdivisions 4a, 4b and 4d; 2) I have not been the subject of any disciplinary action in this or any other state; 3) I have not been subject to any commissioner, court or other orders (including conciliation court orders), in this or any other state, currently in effect or issued within the last five years, with respect to an action or omission in connection with the dispensing of hearing instruments; and 4) I am at least 21 years of age. I understand that approval of this trainee application and status as a trainee creates no rights to or expectation of approval from the Minnesota Department of Health for certification as a hearing instrument dispenser.

 Trainee-Applicant Signature

 Date

(over)

CERTIFIED SUPERVISOR AFFIRMATION: I request that the above-named applicant be authorized to dispense hearing aids as a trainee under my supervision for a period not to exceed twelve months. I know that this person is at least 21 years of age. I certify that I hold a valid credential to dispense hearing aids, that I have read and will comply with the requirements of Minnesota Statute §153A.14, Subdivisions 4a, 4b and 4d, that I have not been subject to any commissioner, court or other orders, currently in effect or issued within the last five years, that were issued with respect to an action or omission in connection with the dispensing of hearing instruments. I understand that the trainee must be under direct supervision until passing the practical examination at which time the trainee may be under indirect supervision until they are certified. The above-named applicant is under my supervision, and I am not supervising more than two trainees at the same time, and am not directly supervising more than one trainee at a time. I shall be responsible for all actions and omissions of the above-named applicant in connection with the dispensing of hearing instruments. I understand that I am liable for satisfying all terms of contracts, written or oral, made by the trainee, including terms relating to products, repairs, warranties, service and refunds. I understand that the trainee will use my credential number on all contracts of sale for as long as I supervise him/her as a trainee. I understand that I am responsible as supervisor for the trainee until the Minnesota Department of Health receives my written and signed statement that I wish to cease supervision of the trainee or until expiration of twelve months.

SUPERVISOR:

Printed Name of Supervisor

HID Certification Number

Business Name and Address:

Name of Business

Street

City

State

Zip

(_____)_____
Business Phone

e-mail address:

Signature of Certified Supervisor

Date

EMPLOYER: If the supervisor is not the employer, list employer information below:

Printed Name of Employer

Employer's Business Name and Address:

Name of Business

Street

City

State

Zip

(_____)_____
Employer's telephone number

CERTIFICATION OF CALIBRATION OF AUDIOMETRIC EQUIPMENT

I HEREBY CERTIFY and understand that any audiometric equipment that I use has been calibrated to the current ANSI standards within twelve (12) months of the date of this application. For purposes of this certification "ANSI" means ANSI S3.6-1989, American National Standard Specification for Audiometers from the American National Standards Institute.

Dated this _____ day of _____, 20_____.

Signature

Date

Name typed or printed