DEPARTMENT OF HEALTH

Hearing Instrument Dispenser

TRAINEE RECIPROCITY APPLICATION

MINNESOTA GOVERNMENT DATA PRACTICE ACT NOTICE. The information requested on this form will be used only by Minnesota Department of Health staff to determine whether the applicant and the supervisor meet requirements of Minnesota Statutes, section 153A.14, subd. 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 except social security number. 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 Statute, section 153A.15, subd. 2.

Instructions

This application must be completed along with the certification application. 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 to the Health Occupations Program at the above address. You must **receive written approval from the Minnesota Department of Health** before dispensing hearing instruments under indirect supervision.

Personal Information

Last Name | First Name | M.I

Home Address | City | State | ZIP

Home Phone | Date of Birth (Applicant must be at least 21 years of age)

Business Name and Address, if approved as a trainee

Business Name | Business Phone Number

Business Address | City | State | ZIP

RECIPROCITY – APPLICANT AFFIRMATION: *I hereby make application to dispense hearing instruments in Minnesota. I understand that as a trainee, I must dispense hearing aids under indirect supervision of a certified dispenser until I have taken and passed the practical examination. I understand that I must take and pass the examination when next offered if I fail to take and pass the practical examination when next offered, I must dispense under direct supervision until 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 Minnesota Statute, section 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 DISPENSER-SUPERVISOR AFFIRMATION: I request that the above-named applicant be authorized to dispense hearing aids 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 certificate to dispense hearing aids, that I have read and will comply with the requirements of Minnesota Statute §153A.14, subdivisions 4a, 4c 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 applicant must be under indirect supervision until passing the practical examination that is next offered. If the applicant fails to take and pass the practical examination when next offered, they must dispense under direct supervision. 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 applicant 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 until the Minnesota Department of Health receives my written and signed statement that I wish to cease supervision or until expiration of twelve months.

Supervisor

Printed Name of Certified Dispenser - Supervisor | HID Certification Number

Business Name and Address

Name of Business

Home Address | City | State | ZIP

Business Phone

Signature of Certified Dispenser | Date

Employer

If the supervisor is not the employer, list employer information below.

Printed Name of Employer

Business Address | City | State | ZIP

Employers Phone 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 Institutes.

Name Printed

Signature of Certified Dispenser | Date

Minnesota Department of Health
PO Box 64882
St. Paul, MN 55164-0882
651-201-4200
health.hid@state.mn.us
www.health.state.mn.us

05/29/2024

To obtain this information in a different format, call: 651-201-4200.