Hearing Instrument Dispenser Trainee Reciprocity Supervision Form

In accordance with Minnesota Statutes, section 13.41 (https://www.revisor.mn.gov/statutes/cite/13.41), all data submitted on this license application shall be classified public information upon issuance of a license.

This form must be completed by <u>each</u> certified hearing instrument dispenser (HID) who will be providing supervision to the applicant.

Applicant Information

Applicant Name:	
Home Address:	
Home/Cell Phone Number:	
Email Address:	
Employer Name:	
Employer Address:	
Employer Phone Number:	

HID Supervisor Information

The applicant's supervisor is required to complete this section of the form. Trainee applications submitted without supervision information will not be processed. Send the completed form to the applicant.

Supervisor Name:	
Supervisor MN HID Certification Number:	
Supervisor Telephone Number:	
Supervisor Email:	
Employer Name:	
Employer Address:	
Employer Phone Number:	

Supervisor Acknowledgement

☐ I acknowledge, as outlined in Minnesota Statutes 153A.14 Subd. 4a (b), that the applicant is under my supervision and I am not supervising more than two (2) trainees at a time, and I am not directly supervising more than one trainee at a time. I shall be responsible for all actions and omissions of the applicant in connection with the dispensing of prescription hearing aids.

☐ I acknowledge, that I hold a valid credential to dispense prescription hearing aids and will comply with the requirements of Minnesota Statutes section 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 (5) years, that were issued with respect to an action or omission in connection with the dispensing of prescription hearing instruments.

☐ I acknowledge, the applicant is authorized to dispense prescription hearing aids as a trainee under my supervision for a period not to exceed twelve (12) months. I know that this person is at least 21 years of age.

☐ I acknowledge, that the trainee must be under indirect supervision until passing the hearing instrument dispenser 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.

☐ I acknowledge, that I am liable for satisfying all terms of the contracts, written or oral, made by the trainee, including terms relating to products, repairs, warranties, service and refunds. I understand the trainee will use my credential number on all contracts of sale for as long as I am their supervisor.

☐ I acknowledge, 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, the trainee period automatically expires two months following notice of the trainee passing all examination requirements, or until expiration of twelve (12) months.

Supervisor's Name (Print): _____

Supervisor's Signature: _____

Date: _____

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

06/05/2026

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