State of Illinois
Illinois Department of Public Health

RECIPROCITY LICENSE CHECKLIST

This checklist is a tool to ensure you have enclosed all required items for the reciprocity of hearing aid dispenser licenses.

- ❑ Fees – This includes fees for additional and duplicate licenses. Additional licenses are for locations where you work more than eight hours a week. Duplicate or additional licenses are $20 each.

- ❑ Child support section – You ***must*** circle either “am” or “am not.”

- ❑ Malpractice insurance – Current certificate of insurance, including expiration date and coverage amount and indicating specialty is *hearing instrument dispenser*. Audiology or audiologist is ***not*** acceptable unless you are an Illinois licensed audiologist.

- ❑ Transcripts or proof of degree must include the original stamp or seal of the college. If applicable, you must show proof of the four specific classes required in Section 50/8e of the act.

- ❑ Proof of licensure.

- ❑ Proof of comparable exam.

Failure to submit required items will delay processing of your application.

Fees are non refundable.

State of Illinois
Illinois Department of Public Health

400_____080 405_____100
410_____500 415_____200
430_____020

HEARING INSTRUMENT CONSUMER PROTECTION PROGRAM

DISPENSER LICENSE APPLICATION

Applicant's Name _____

For **ALL** applications, Complete Part A. The child support section must be completed to have application processed (Part A, Page 3). Specific law references include (225 ILCS 50/ Hearing Instrument Consumer Protection Act) and (77 Ill. Adm. Code 682 Hearing Instrument Consumer Protection Code).

For **INITIAL** applications only, applicants must have passed both the written and practical examinations. Applications must be accompanied by the following materials: applicable fees, proof of liability insurance, and proof of educational requirements, (Sec. 50/8b and code, Sec. 682.200 a-d).

For **RENEWAL** applications only, complete Part A, send applicable fees, and proof of 20 continuing education hours. A minimum of 10 hours must be nonmanufacturer sponsored hours.

For **TRAINEE** applications only, complete Part A. Have Part B completed by supervisor. The following information will also need to be provided: applicable fees, proof of liability insurance, and proof of educational requirements (Sec. 50/8b and code, Sec. 682.200 a-d). Written and practical exams do not need to be completed prior to trainee licensure.

For **RECIPROCITY** applications only, complete Part A, and Part C of the application. The following information will also need to be provided with the application: applicable fees, proof of liability insurance, proof of current license in another jurisdiction and valid statement of licensing requirements, proof of educational requirements (Sec. 50/8b and code, Sec. 682.200 a-d), and state verification form (Part C, page 2).

TYPE OF LICENSE AND FEES

Select the license for which you are applying and pay the appropriate fee(s).

❑ **INITIAL**
Application Fee $80
License Fee (2 years) $200
*Duplicate License (if applicable)

❑ **TRAINEE**
License Fee (6 months) $100
*Duplicate License (if applicable)

❑ **RENEWAL**
License Fee (2 years) $200
**Late Fee (if applicable) $200
*Duplicate License (if applicable)

❑ **RECIPROCITY**
Application Fee $80
License Fee $200
Reciprocity Fee $500
*Duplicate License (if applicable)

***Each Additional/Duplicate License is $20 in addition to other application fees.**
**Must be postmarked by the expiration date

TOTAL AMOUNT ENCLOSED $_____

Fees are nonrefundable. Make check or money order payable to: **IDPH – Hearing Instrument Program**.
Submit application, fees and supporting documents to:

Illinois Department of Public Health
Hearing Instrument Program
535 W. Jefferson St., Third Floor
Springfield, IL 62761

Telephone 217-782-4733 Fax 217-557-5324 E-mail dph.visionandhearing@illinois.gov

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State of Illinois
Illinois Department of Public Health

OFFICE USE ONLY
Check: Y N
Amount: _____
Type: I RN T RC

HEARING INSTRUMENT CONSUMER PROTECTION PROGRAM

DISPENSER LICENSE APPLICATION

Part A

PLEASE PRINT

NAME _____
(Last) (First) (MI)

HOME ADDRESS _____
(Street or P.O. Box)

_____
(City) (State) (ZIP Code)

DAYTIME PHONE (_____) _____ FAX NUMBER (_____) _____

E-MAIL ADDRESS _____

COUNTY _____ DATE OF BIRTH _____ SEX: ❑ M ❑ F

HIGHEST LEVEL OF EDUCATION COMPLETED
❑ Associates Degree ❑ B.S./B.A. ❑ M.S./M.A. ❑ Ph.D./Ed.D./Au.D. ❑ Other

---

MALPRACTICE/LIABILITY INSURANCE EXPIRATION DATE _____
*Applications must be accompanied by proof of liability insurance.

PRIMARY BUSINESS INFORMATION

BUSINESS NAME _____

BUSINESS ADDRESS _____

CITY _____ STATE _____ ZIP _____

COUNTY _____ PHONE (_____) _____

FAX (_____) _____

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Additional locations requiring license (more than eight hours per week):

BUSINESS NAME ______________________________

BUSINESS ADDRESS ______________________________

CITY ______________________ STATE __________ ZIP __________

COUNTY ______________________ PHONE (_____) __________

FAX (_____) __________________

BUSINESS NAME ______________________________

BUSINESS ADDRESS ______________________________

CITY ______________________ STATE __________ ZIP __________

COUNTY ______________________ PHONE (_____) __________

FAX (_____) __________________

BUSINESS NAME ______________________________

BUSINESS ADDRESS ______________________________

CITY ______________________ STATE __________ ZIP __________

COUNTY ______________________ PHONE (_____) __________

FAX (_____) __________________

BUSINESS NAME ______________________________

BUSINESS ADDRESS ______________________________

CITY ______________________ STATE __________ ZIP __________

COUNTY ______________________ PHONE (_____) __________

FAX (_____) __________________

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State of Illinois
Illinois Department of Public Health

ANSWER THE FOLLOWING QUESTIONS, READ THE COMPLIANCE STATEMENT, COMPLETE THE CHILD SUPPORT PORTION AND SIGN BELOW.

❑ No ❑ Yes Have you ever pleaded no contest or been convicted of a felony or misdemeanor under the laws of the United States or of any state or territory, ever been disciplined by a governmental agency or professional association, or subject to currently effective injunctive or restrictive order as a result of the aforementioned actions?

If Yes: Attach a signed and detailed written explanation, specifically addressing the allegations, the name of the governmental agency bringing the charges, and the nature of any and all disciplinary actions (e.g., fine, probation, suspension, revocation) taken against you. Also attach a copy of final orders concerning such matters.

❑ No ❑ Yes Are you a U.S. citizen or legal alien? If legal alien,

indicate registration number: _____

❑ No ❑ Yes Are you free of infectious disease?

❑ No ❑ Yes Have you been licensed in another state? If yes, what state? _____

I AFFIRM THAT I WILL COMPLY WITH THE PROVISIONS OF THE HEARING INSTRUMENT CONSUMER PROTECTION ACT, THE RULES AND REGULATIONS ISSUED PERTAINING TO THE ACT AND THE REGULATIONS OF THE FEDERAL FOOD AND DRUG ADMINISTRATION. I AFFIRM THAT THE INFORMATION GIVEN IS TRUE, CORRECT AND COMPLETE. I UNDERSTAND THE WILLFUL MAKING OF A FALSE, MISLEADING OR INCOMPLETE STATEMENT CAN BE GROUNDS FOR DISCIPLINARY ACTION BY THE ILLINOIS DEPARTMENT OF PUBLIC HEALTH.

CHILD SUPPORT SECTION

I hereby certify, under penalty of perjury, that I **AM / AM NOT** (circle one) more than 30 days delinquent in complying with a child support order.

You must certify one of the above choices. Failure to certify may result in the denial of your application. Making a false statement may subject you to contempt of court and disciplinary action. (5ILCS 100/10-65 [C])

_____ _____
Print Name Dispenser #ID (if applicable)

_____ _____
Signature Date

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HEARING INSTRUMENT CONSUMER PROTECTION PROGRAM

PROOF OF LICENSURE

Part C

RECIPROCITY LICENSE SECTION ONLY

List all states in which you currently hold a license to dispense hearing instruments. A verification of licensure must be submitted by each state (See License Verification Form, Page C-2).

State	License Number	Date Issued	Current Status (Active or Inactive)	Ever Disciplined (Yes* or No)

*If YES, provide an explanation.

Are you certified by the National Board of Certification? ❑ YES ❑ NO
(Attach a copy)

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HEARING INSTRUMENT CONSUMER PROTECTION PROGRAM

LICENSE VERIFICATION FORM

APPLICANT'S NAME _____

The following sections must be completed by the state licensing board office and mailed directly to:

Illinois Department of Public Health
Hearing Instrument Consumer Protection Program
535 W. Jefferson St., Third Floor
Springfield, IL 62761

Title of License _____ License Number _____

Original Issue Date _____ Expiration Date _____

License Status

❑ Active ❑ Inactive ❑ Other
(Attach explanation)

Licensure Method

❑ Grandfathering ❑ Reciprocity/Endorsement ❑ Examination

If licensed by examination, complete the following:

Name of Examination _____ Date of Examination _____

Has any disciplinary action been taken against this license? ❑ YES ❑ NO
If YES, provide documentation regarding disciplinary action.

Signature _____ Title _____ Date _____ Phone Number _____ State of _____	Affix Official Seal

C-2

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