State of Illinois
Illinois Department of Public Health

400 _____080 405 _____ 100
410 _____ 500 415 _____ 200
430 _____ 020

ILLINOIS DEPARTMENT OF PUBLIC HEALTH

Hearing Instrument Consumer Protection Program

DISPENSER LICENSE APPLICATION

Applicant's Name _____

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

For **INITIAL** applications only: To apply for an initial license, 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 of the act, Sec. 50/8b and code, Sec. 682.200 a-d.

For **RENEWAL** applications only: In addition to filling out Part A and sending applicable fees, 20 continuing education unit hours will need to be submitted; a minimum of 10 hours must be non manufacturer sponsored hours.

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

TYPE OF LICENSE AND FEES

Please select the license for which applying and pay the appropriate fees listed below.

☐ **INITIAL**

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

☐ **RENEWAL**

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

☐ **TRAINEE**

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

☐ **RECIPROCITY**

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

***Additional/Duplicate Licenses are $20 for all applications.**
**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 217-524-2396 Fax 217-524-4201 E-mail dph.visionandhearing@illinois.gov

State of Illinois
Illinois Department of Public Health

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

ILLINOIS DEPARTMENT OF PUBLIC HEALTH

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 (_____)_____ Cell (_____)_____

E-MAIL ADDRESS _____

COUNTY _____ DATE OF BIRTH _____ Sex ☐ M ☐ F

HIGHEST LEVEL OF EDUCATION COMPLETED

☐ Associates Degree ☐ BS/BA ☐ MS/MA ☐ Ph.D./Ed.D./Au.D. ☐ Other

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MALPRACTICE/LIABILTY INSURANCE EXPIRATION DATE _____
*All applications must be accompanied by proof of liability insurance.

PRIMARY BUSINESS INFORMATION

BUSINESS NAME _____

BUSINESS ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

COUNTY _____ PHONE (_____) _____

FAX (_____) _____

State of Illinois
Illinois Department of Public Health

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

BUSINESS NAME _____

BUSINESS ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

COUNTY _____ PHONE (_____) _____

FAX (_____) _____

BUSINESS NAME _____

BUSINESS ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

COUNTY _____ PHONE (_____) _____

FAX (_____) _____

BUSINESS NAME _____

BUSINESS ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

COUNTY _____ PHONE (_____) _____

FAX (_____) _____

BUSINESS NAME _____

BUSINESS ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

COUNTY _____ PHONE (_____) _____

FAX (_____) _____

State of Illinois
Illinois Department of Public Health

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

☐ No ☐ Yes Has applicant 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; been disciplined by another governmental or professional association for actions which involved fraud of dishonesty; or subject to any currently effective injunctive or restrictive order as a result of the aforementioned actions?

☐ No ☐ Yes Is applicant a U.S. citizen or legal alien? If alien, indicate registration number: _____

☐ No ☐ Yes Is applicant 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 AND THE REGULATIONS OF THE FEDERAL FOOD AND DRUG ADMINISTRATION. I AFFIRM THAT THE INFORMATION GIVEN IS TRUE, CORRECT AND COMPLETE. I UNDERSTAND THAT 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 hearby 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

State of Illinois
Illinois Department of Public Health

Part B

TRAINEE LICENSE SECTION ONLY

SUPERVISIOR'S INFORMATION

NAME _____
(Last) (First) (M.I.)

HOME ADDRESS_____
(Street or P.O. Box)

_____
(City) (State) (ZIP Code)

BUSINESS NAME _____

ADDRESS _____
(Street or P.O. Box)

_____
(City) (State) (ZIP Code)

Business Phone (_____) _____ E-MAIL _____

Do you currently hold an Illinois Hearing Aid Dispenser License or Illinois Audiology License?

☐ YES ☐ NO

If YES, license #_____ Issue Date _____ Exp Date _____

Must provide proof of liability insurance

State of Illinois
Illinois Department of Public Health

Illinois Department of Public Health
Hearing Instrument Consumer Protection Program
Supervisor's Affirmation

I, _____, agree to be the supervisor of _____ while working toward his/her Hearing Instrument Dispenser License. In accordance with Illinois Department of Public Health Hearing Instrument Consumer Protection Administrative Code under Section 682.215, the above mentioned trainee shall perform the functions of a hearing instrument dispenser under my supervision. I will provide 100 percent direct supervision until the trainee has obtained a Hearing Instrument Dispenser License. I understand that the trainee license is limited to six months.

I also supervise the following trainees:

1. _____ ID # _____

2. _____ ID # _____

Signatures

Trainee _____ Date _____

Supervisor _____ Date _____

State of Illinois
Illinois Department of Public Health

Part C

RECIPROCITY LICENSE SECTION ONLY

PROOF OF LICENSURE

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, please explain.

Are you certified by the National Board of Certification? ☐ YES ☐ NO
(Please submit a copy)

State of Illinois
Illinois Department of Public Health

Illinois Department of Public Health
Hearing Instrument 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, please complete the following:

Name of Exam_____ Date of Exam_____

Has any disciplinary action been taken against this license? ☐ YES ☐ NO
If YES, please provide our office with any documentation regarding disciplinary action.

Do you have any derogatory information concerning this person? ☐ YES ☐ NO
If YES, please explain.

Signature_____

Title _____

Date _____

Phone Number_____

State of_____

Affix Official Seal