OFFICE USE ONLY
Check: Y N
Amount: _____

215 _____ 115

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
Hearing Instrument Consumer Protection Program

DISPENSER LICENSE RENEWAL APPLICATION

Name _____ ID# _____

E-mail address (if available) _____
Cell Phone Number _____

HOME ADDRESS INFORMATION

Street _____

City _____ State _____ ZIP Code _____

County _____ Phone (_____) _____

PRIMARY BUSINESS INFORMATION

Business Name _____

Business Address _____

City _____ State _____ ZIP Code _____

County _____ Phone (_____) _____

NOTE: Please list additional locations from which you dispense more than eight hours a week on page 2 of this application.

* Malpractice/Liability Insurance Expiration Date: _____

Two-year license renewal fee $115 $_____

Additional locations (from page 2) $10 each $_____

Duplicate license fee $10 $_____

Late fee ($115.00 if not post-marked by expiration date) $_____

TOTAL FEES ENCLOSED $_____

Make check or money order payable to IDPH - Hearing Instrument Program

DISPENSER LICENSE RENEWAL APPLICATION

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

Business Name _____

Business Address _____

City _____ State _____ ZIP Code _____

County _____ Phone (_____)_____

Business Name _____

Business Address _____

City _____ State _____ ZIP Code _____

County _____ Phone (_____)_____

Business Name _____

Business Address _____

City _____ State _____ Zip Code _____

County _____ Phone (_____)_____

* According to the Illinois Administrative Procedures Act, each state agency must require license holders to certify the following:

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

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

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.

_____ _____
Type or Print Name Dispenser ID # (4 digit)

_____ _____
Signature Date

Submit application and fees to: IDPH - Hearing Instrument Program
535 W. Jefferson St., Third Floor
Springfield, IL 62761
Questions? Call 217-524-2396 Fax 217-524-4201
E-mail: dph.visionandhearing@illinois.gov

Please Note: Malpractice/Liability Insurance Expiration Date and Child Support Portion must be completed on this application.