OFFICE USE ONLY
Check: Y N
Amount: ____________

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ILLINOIS DEPARTMENT OF PUBLIC HEALTH
Hearing Instrument Consumer Protection Program

WRITTEN EXAMINATION REGISTRATION

PLEASE PRINT
NAME ____
(Last) (First) (M.I.)

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

____
(City) (State) (ZIP Code)

DAYTIME PHONE (_______)________________ FAX NUMBER (______)__________________

EMAIL ADDRESS ____

EXAMINATION DATES

At a minimum, tests will be given every other month. Please call 217-524-2396 for the test date prior to sending in your application. Please list exam date requested: ____.

Tests are held at the **Illinois Department of Public Health, 535 W. Jefferson St., Third Floor, Springfield, IL 62761.**

All registrations must be accompanied by a check or money order in the amount of $125 made payable to: **Illinois Department of Public Health** at least two weeks in advance of written examination.

FEES MAY BE APPLIED TO FUTURE TESTING IF DEPARTMENT IS NOTIFIED OF CANCELLATION PRIOR TO 48 HOURS BEFORE SCHEDULED EXAM.

Questions? Telephone 217-524-2396 Fax 217-524-4201 E-mail: dph.visionandhearing@illinois.gov
Submit registration to:
Illinois Department of Public Health
Hearing Instrument Program
535 W. Jefferson St., Third Floor
Springfield, IL 62761