ILINOIS 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
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

MALPRACTICE/LIABILITY 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 (___) __________________________
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 (_____) __________________________
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 or 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? ____________


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
**Part B**

**TRAINEE LICENSE SECTION ONLY**

**SUPERVISOR’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**
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 ________
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).

<table>
<thead>
<tr>
<th>State</th>
<th>License Number</th>
<th>Date Issued</th>
<th>Current Status (Active or Inactive)</th>
<th>Ever Disciplined (Yes* or No)</th>
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*If YES, please explain.

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