



# Hearing Aid Specialist License Application Packet

## Contents:

1. 654-014 ..... Contents List/SSN Information/Mailing Information..... 1 page
2. 654-032 ..... Application Instructions Checklist .....3 pages
3. 654-067 ..... Hearing Aid Specialist License Requirements.....2 pages
4. 654-002 ..... Hearing Aid Specialist License Application.....6 pages
5. RCW/WAC and Online Website Links..... 1 page

## Important Social Security Number Information:

If you have a Social Security Number, the law requires you to disclose it on your application for a professional or occupational license. [42 U.S.C. § 666\(a\)\(13\)](#); [RCW 26.23.150](#). It will be used under the state’s child support enforcement program to locate individuals for purposes of establishing paternity and establishing, modifying, and enforcing support obligations. You are not required to have or obtain a Social Security Number to apply for or obtain a license from the Department of Health. If you do not have a Social Security Number, you are still eligible to apply for and obtain a credential if you meet the requirements. Please see the [Declaration of No Social Security Number Form](#). Please call the Customer Service Center at 360-236-4700 if you have questions.

## In order to process your request:

**Mail your application with initial documentation and your check or money order payable to:**

Department of Health  
P.O. Box 1099  
Olympia, WA 98507-1099

**Send other documents not sent with initial application to:**

Hearing and Speech Credentialing  
P.O. Box 47877  
Olympia, WA 98504-7877

## Contact us:

360-236-4700

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email [civil.rights@doh.wa.gov](mailto:civil.rights@doh.wa.gov).

(This page intentionally left blank.)

## Application Instructions Checklist

**Important background check Information:** Washington State law authorizes the Department of Health to obtain fingerprint-based background checks for licensing purposes. This check may be through the Washington State Patrol and the Federal Bureau of Investigation (FBI). This may be required if you have lived in another state or if you have a criminal record in Washington State. This would be at your own expense.

All information should be printed clearly in blue or black ink. It is your responsibility to submit the required forms.

**Application Fee.** This fee is non-refundable. You can check the online [fee page](#) for current fees.

**Select if the following applies:**  
Spouse or Registered Domestic Partner of Military Personnel

**1. Demographic Information:**

**Social Security Number:** You must list your social security number on your application. You are not required to have or obtain a Social Security Number to apply for or obtain a license from the Department of Health. Please see the [Declaration of No Social Security Number Form](#). Please call the Customer Service Center at 360-236-4700 if you do not have one.

**National Provider Identifier Number (NPI):** The National Provider Identifier (NPI) is a standard unique identifier for health care professionals available from the Federal Centers for Medicare and Medicaid Services. The NPI is a 10 digit numeric identifier. If you have a NPI number, provide this on your application.

**Legal Name:** List your full name: first, middle, and last.

**Definition of legal name:** “Legal name” is the name appearing on your official certificate of birth or, if your name has changed since birth, on an official marriage certificate or an order by a court. The court must have the legal authority to change your name. We may ask you to prove your legal name. If you use any name other than your legal name on this form, your application may be denied.

**Birth date:** Provide the month, day, and year of your birth.

**Address:** List the address we should use to send any information about your license. Be sure to include the city, state, zip code, county, and country. This will be your permanent address with the Department of Health until we have been notified of a change. See [WAC 246-12-310](#).

**Phone, Fax and Cell Numbers:** Enter your phone, fax, and cell numbers, if you have them.

**Email:** Enter your email address, if you have one.

**Place of Business:** Enter your place of business name and address.

**Other Name(s):** Indicate whether you are known or have been known under any other names. If you have a name change, you must notify the Department of Health in writing. You must include proof of this change. See [WAC 246-12-300](#).

**2. Personal Data Questions:**

All applicants must answer the same personal data questions. They are focused on your fitness to practice the essential skills of this profession. If you answer “yes” to any questions in this section, you must provide an appropriate explanation. You must also provide the documentation listed in the note after the question. If you do not provide this, your application is incomplete and it will not be considered.

- Question 5 includes misdemeanors, gross misdemeanors and felonies. You do not have to answer yes if you have been cited for traffic infractions. You can get copies of court records through the county courthouse where the conviction, plea, deferred sentence, or suspended sentence was entered.
- If you have been granted certificate(s) of restoration of opportunity, please provide a certified copy of each certificate.
- Another jurisdiction means any other country, state, federal territory, or military authority.

**3. Other License, Certification, or Registration:**

List all states, including Washington, where credentials are or were held. Attach additional completed pages if you need more space. You must also print the [Verification Form](#) and provide it to each state or jurisdiction that you have listed, requesting that they complete and submit the form directly to the Department of Health.

**4. Agent Registration (Contact Person):**

List name and address of registered agent.

**5. Education:**

Graduate from a two-year degree program or a nine-month certificate program in hearing aid specialist instruction, from a board-approved program. Request official transcripts to be sent directly from your college or university to the Department of Health.

**6. Experience:**

Beginning with current employment, list all activities and account for all periods of time from graduation to the present time. A resume will **not** substitute for completion of the application. If you need more space, attach a sheet of paper.

**7. Bonding Requirement:**

Every individual shall be covered by a surety bond or security in lieu of a bond in the sum of \$10,0000. Please refer to [RCW 18.35.240](#).

**8. Applicant's Attestation:**

You must sign and date this for us to process the application.

You may apply for licensure as a hearing aid specialist by completing the following requirements:

- Application and [fee](#);
- Successfully pass the International Hearing Society written licensing examination.
- The [Jurisprudence Examination](#):

## **For Spouses and Registered Domestic Partners of Military Personnel Being Transferred or Stationed in Washington:**

Under state law, if you are the spouse or state-registered domestic partner of a servicemember of any branch of the U.S. Military, to include Guard or Reserve, and are applying for a health care professional credential in this state, you may be eligible to have the processing of your application expedited to receive your credential more quickly.

Documents to submit with your application should include the following:

- A copy of your spouse's or registered domestic partner's military transfer orders to Washington State.
- One of the following:
  - A copy of your marriage certificate to show proof of marriage; or
  - A copy of a state's declaration or registration showing you are in a state registered domestic partnership with a member of the U.S. military.

### **Other Information:**

You will be mailed a letter regarding the deficiencies of your application if the application is incomplete.

- The initial license will expire on your birthday unless the initial license is issued within 90 days of your birthday.
- Licenses must be renewed every year on your birthday as provided in chapter [246-12 WAC, Part 2](#). A courtesy renewal notice will be mailed to your address on record. You must keep your address current with us. Any renewal postmarked or presented to the department after midnight on the expiration date is late.
- Information regarding hearing and speech credentialing is available on our [website](#).

### **Continuing Education Requirements:**

Hearing aid specialists must complete a minimum of 30 hours of continuing education every three years.

The required continuing education must be obtained during the period between renewals. For more information on the continuing education requirement, please see [WAC 246-828-510](#) and [246-12 WAC, Part 7](#).

Information regarding hearing and speech credentialing is available on our [website](#).

(This page intentionally left blank.)

## License Requirements

Study the Washington State hearing aid specialist laws. [RCW 18.35](#) and [WAC 246-828](#).

- Agent Registration (Contact Person);
- Bonding or security requirement;
- Out-of-state Credential Verification form completed by each state(s) in which you hold or have held a credential. The state will complete its portion of the verification form and mail it directly to Washington State.

If you are a **graduate of a board-approved two-year degree program** you must also:

- Provide Official Transcripts: Your transcripts must show program completion date and must come directly from your college or university to the Department of Health.

If you are a **graduate of a board-approved nine month certificate program** in hearing aid specialist instruction you must also:

- Provide Official Transcripts: Your transcripts must show program completion date and must come directly from your college or university to the Department of Health.
- Successfully pass a practical examination administered by the Board of Hearing and Speech.

If you are requesting **licensure by endorsement**, you must also:

- Hold a current, unsuspended, unrevoked license from another jurisdiction and have been actively practicing as a licensed hearing aid specialist in another jurisdiction for a least 48 of the last 60 months.  
Please list your active practice of at least 48 months in another jurisdiction in the experience section of the application.
- Proof of completion of advanced certification from either the International Hearing Society or the National Board for Certification in Hearing Instrument Sciences must be submitted from the organization directly to the Department of Health.

### Board Approved Two-Year Degree Programs:

- Spokane Falls Community College
- Bates Technical College

### Board Approved Nine-Month Certificate Programs:

- Washington Hearing Society Hearing Aid Specialist Training Program

## Examination Information:

### Written Examination:

The written examination required of all hearing aid specialist applicants is the International Hearing Society (IHS) Licensing Examination. It is a computer-based test and is available to take at various testing centers statewide.

Written examination procedures are as follows:

- Department of Health credentialing staff will review your application to ensure you are eligible to sit for the examination. If you are eligible, staff will notify IHS of your eligibility.
- IHS will contact you with instructions on how to create an online account, schedule, and pay for the examination. They will also send you a study guide.
- Once you have completed your examination, credentialing staff will notify you of your score by email.
- If you pass the examination, the licensure process will proceed.
- If you don't pass the examination, you're eligible to retake the examination. Credentialing staff will notify IHS of your retake eligibility.

### **Practical Examination:**

The practical examination is a requirement of licensure if you have completed a nine-month board-approved hearing aid specialist program per [RCW 18.35.040](#) and [WAC 234-828-020](#). The examination is administered by member of the Board of Hearing and Speech. Date of the practical examination will be posted on the [Hearing and Speech website](#).

Practical examination procedures are as follows:

- Applicants must send a Hearing Aid Specialist Application and fee to the Department of Health at least 60 days before the scheduled examination.
- Department of Health credentialing staff will review your application to ensure you are eligible to sit for the examination.
- Once you have completed your examination, credentialing staff will notify you of your score by email.
- If you pass the examination, the licensure process will proceed.
- If you don't pass the examination, you're eligible to retake the next regularly scheduled examination.



Date  
Stamp  
Here

Revenue: 0216020000

## Hearing Aid Specialist License Application

Please indicate which you are applying for:

- Board-approved two year degree program     
  Board-approved nine month certificate program  
 Licensure by endorsement

Select if the following applies:       Spouse or Registered Domestic Partner of Military Personnel

### 1. Demographic Information

<b>Social Security Number (SSN)</b> (If you do not have a SSN, see instructions)	<b>National Provider Identifier Number (NPI)</b> (Enter 10 digit number)	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Prefer Not to Answer <input type="checkbox"/> X
---	---	--

Name	First	Middle	Last
------	-------	--------	------

Birth date (mm/dd/yyyy)

Address

City	State	Zip Code	County
------	-------	----------	--------

Country

Phone (enter 10 digit #)	Fax (enter 10 digit #)	Cell (enter 10 digit #)
--------------------------	------------------------	-------------------------

Email address

Mailing address if different from above address of record

City	State	Zip Code	County
------	-------	----------	--------

Country

Note: The mailing and email addresses you provide will be your addresses of record. It is your responsibility to maintain current contact information on file with the department.

Place of Business Name

Address

City	State	Zip Code	County
------	-------	----------	--------

Have you ever been known under any other name(s)?    Yes    No   If yes, list name(s):

Will documents be received in another name?    Yes    No   If yes, list name(s):

## 2. Personal Data Questions

Yes No

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please attach explanation.....

**“Medical Condition”** includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, intellectual disabilities, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

If you answered yes to question 1, explain:

- 1a. How your treatment has reduced or eliminated the limitations caused by your medical condition.  
1b. How your field of practice, the setting or manner of practice has reduced or eliminated the limitations caused by your medical condition.

**Note: If you answered “yes” to question 1, the licensing authority will assess the nature, severity, and the duration of the risks associated with the ongoing medical condition and the ongoing treatment to determine whether your license should be restricted, conditions imposed, or no license issued.**

**The licensing authority may require you to undergo one or more mental, physical or psychological examination(s). This would be at your own expense. By submitting this application, you give consent to such an examination(s). You also agree the examination report(s) may be provided to the licensing authority. You waive all claims based on confidentiality or privileged communication. If you do not submit to a required examination(s) or provide the report(s) to the licensing authority, your application may be denied.**

2. Do you currently use chemical substance(s) in any way which impair or limit your ability to practice your profession with reasonable skill and safety? If yes, please explain .....

**“Currently”** means within the past two years.

**“Chemical substances”** include alcohol, drugs, or medications, whether taken legally or illegally.

3. Have you ever been diagnosed with, or treated for, pedophilia, exhibitionism, voyeurism or frotteurism?.....

4. Are you currently engaged in the illegal use of controlled substances?.....

**“Currently”** means within the past two years.

**Illegal use of controlled substances** is the use of controlled substances (e.g., heroin, cocaine) not obtained legally or taken according to the directions of a licensed health care practitioner.

**Note: If you answer “yes” to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The department does criminal background checks on all applicants.**

5. Have you **ever** been convicted, entered a plea of guilty, no contest, or a similar plea, or had prosecution or a sentence deferred or suspended as an adult or juvenile in any state or jurisdiction? ..

**Note: If you answered “yes” to question 5, you must send certified copies of all court documents related to your criminal history with your application. If you do not provide the documents, your application is incomplete and will not be considered.**

**If you have been granted certificate(s) of restoration of opportunity, please provide a certified copy of each certificate.**

**To protect the public, the department considers criminal history. A criminal history may not automatically bar you from obtaining a credential. However, failure to report criminal history may result in extra cost to you and the application may be delayed or denied.**

## 2. Personal Data Questions (cont.)

Yes No

6. Have you ever been found in any civil, administrative or criminal proceeding to have:
- a. Possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes? .....
  - b. Diverted controlled substances or legend drugs?.....
  - c. Violated any drug law? .....
  - d. Prescribed controlled substances for yourself? .....
7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", please attach an explanation and provide copies of all judgments, decisions, and agreements? .....
8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority? .....
9. Have you ever surrendered a credential like those listed in number 8, in connection with or to avoid action by a state, federal, or foreign authority? .....
10. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence, or malpractice in connection with the practice of a health care profession? .....
11. Have you ever been disqualified from working with vulnerable persons by the Department of Social and Health Services (DSHS)? .....

## 3. Other License, Certification, or Registration

List all states, including Washington, where credentials are or were held. Specifically list credentials granted as temporary, reciprocity, exemption or similar with type, date, grantor, and if credential is current.

State/Jurisdiction	Profession	Type of Credential	Certificate or License		Active	Inactive
			Yr Issued	Number		

An "Out of State Credential Verification form is enclosed and must be sent to each state listed above. Enter your full name and birth date at the top of the form so the state may identify you. Also contact each state board listed for any fees they might charge you for processing the verification form.

## 4. Agent Registration (Contact Person)

Pursuant to [RCW 18.35.230](#), each license holder shall name a registered agent to accept service of process for any violation of this chapter or rule adopted under this chapter. This registered agent can be the owner or manager of the business; your attorney; or someone who will accept the responsibility of receiving legal documents should you not be available to accept them.

The registered agent may be released at the expiration of one year after the license issued under this chapter has expired or been revoked if no legal action has been instituted against the license holder.

Name of Registered Agent \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

## 5. Education

List in date order your education.

A transcript is to be requested from the school(s) and sent directly to the Department of Health

Full Name, City and State Schools Attended	Degree Earned	Attendance	
		Entrance Date	Ending Date

## 6. Experience

List all experience in date order.

Indicate Type of Experience or Practice and Location	Inclusive Dates of Experience	
	Entrance Date	Ending Date

## 7. Bonding Requirement

[RCW 18.35.240](#) Every individual engaged in the fitting and dispensing of hearing instruments shall be covered by a surety bond of \$10,000 or more, for the benefit of any person injured or damaged as a result of any violation by the licensee or permit holder, or their employees or agents, of any of the provisions of this chapter or rules adopted by the secretary.

In lieu of the surety bond required by this section, the licensee or permit holder may deposit cash or other negotiable security in a banking institution as defined in [RCW 30.04](#) or a credit union as defined in [RCW 31.12](#).

I, \_\_\_\_\_, do hereby certify that I am covered by Surety Bond  
Applicant's Name

Number \_\_\_\_\_ with \_\_\_\_\_

Surety Company/Banking Institute, whose Agent is \_\_\_\_\_ at

\_\_\_\_\_  
Agency Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip Code

Effective Date of Surety Bond \_\_\_\_\_  
mm/dd/yyyy

Signature of Applicant \_\_\_\_\_ Date \_\_\_\_\_  
mm/dd/yyyy

## 8. Applicant's Attestation

I, \_\_\_\_\_, declare under penalty of perjury under the laws of the state  
(Name of Applicant)  
of Washington that the following is true and correct:

- I am the person described and identified in this application.
- I have read [RCW 18.130.170](#) and [RCW 18.130.180](#) of the Uniform Disciplinary Act.
- I have answered all questions truthfully and completely.
- The documentation provided in support of my application is accurate to the best of my knowledge.
- I have read all laws and rules related to my profession.

I understand the Department of Health may require more information before deciding on my application. The department may independently check conviction records with state or federal databases.

I authorize the release of any files or records the department requires to process this application. This includes information from all hospitals, educational or other organizations, my references, and past and present employers and business and professional associates. It also includes information from federal, state, local or foreign government agencies.

I understand that I must inform the department of any past, current or future criminal charges or convictions. I will also inform the department of any physical or mental conditions that jeopardize my ability to provide quality health care. If requested, I will authorize my health providers to release to the department information on my health, including mental health and any substance abuse treatment.

By: \_\_\_\_\_ Dated \_\_\_\_\_  
(Original Signature of Applicant) (mm/dd/yyyy)



## **RCW/WAC and Online Website Links**

### **RCW/WAC Links**

[Uniform Disciplinary Act, RCW 18.130](#)

[Administrative Procedure Act, RCW 34.05](#)

[Administrative Procedures and Requirements, WAC 246-12](#)

[Hearing and Speech Laws, RCW 18.35](#)

[Hearing and Speech Rules, WAC 246-828](#)

### **Online**

[Board of Hearing and Speech, Web Page](#)