Iowa Board of Hearing Aid Specialists

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Phone: 515-281-0254

Temporary Permit – Schedule for Supervision Form

1. Name of Temporary Permit Applicant: _____

2. Applicant's Address: _____

3. Applicant's City, State and Zip: _____

4. Applicant's Phone #: _____ Applicant's Email: _____

5. Applicant's Date of Birth: _____ Applicant's SSN: _____

6. Name of Supervisor: _____ Supervisor License #: _____

7. Supervisor's Business Name: _____

8. Supervisor's Business Address: _____

9. Supervisor's City, State and Zip: _____

Supervision Schedule[i]

10. Describe the type of supervision to be provided during the first 90 days: _____

Estimated time: (required min. = 20 hours/ week direct supervision) _____

11. Describe the type of supervision to be provided after the first 90 days: _____

Estimated time: (required min. = 20 hours/ week direct supervision) _____

12. List of subjects to be covered during training: _____

_____

13. Books and materials to be used for training: _____

_____

[i] To complete this supervision schedule, refer to the Competency Model in the IHS Study Guide and the requirements of Iowa Administrative Code 481—2060.2, 2060.3.

Revised 04/2025