IOWA | Department of Inspections, Appeals, & Licensing

Temporary Permit - Schedule for Supervision Plan

Hearing Aid Specialists

Name of temporary permit applicant: _____

Applicant's address: _____

City: _____ State: _____ Zip: _____

Email Address: _____Phone Number: _____

Supervisor Information

(To be completed by the supervisor)

Supervisor's Name: _____

License #: _____ Supervisor's Phone Number: _____

Supervisor's Email Address: _____

Supervisor's Mailing Address: _____

City: _____ State: _____ Zip: _____

Plan for Supervision

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

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

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

Estimated time: *(example = x hours/week direct supervision)*

The supervisor will provide instruction and ensure understanding in the following areas as they relate to the fitting, selection, and sale of hearing aids, as required by Iowa Code:

☐ Physics of sound ☐ Anatomy and physiology of hearing ☐ unction and operation of hearing aids

The supervisor will review and discuss:

- ☐ Medical and rehabilitation facilities available in the area served
- ☐ Resources for both children and adults with hearing problems

The supervisor will address:

- ☐ Situations and conditions in which the use of a hearing aid is considered inappropriate

Books and materials to be used for training:

I, attest that I have completed this form, and all the information submitted herein is truthful and accurate. I understand my failure to answer questions contained in this form truthfully and completely may lead to denial, revocation, or other disciplinary sanction of my license.

_____ _____

Temporary Permit Applicant's Signature *Date*

_____ _____

Supervisor's Signature *Date*

Department of Inspections, Appeals, & Licensing
Hearing Aid Specialists
6200 Park Avenue, Suite 100
Des Moines, IA 50321-1270
Email: pld-licensure@dial.iowa.gov
Phone: 515-281-0254