



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
- Function 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

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