Iowa Board of Hearing Aid Specialists
Iowa Department of Inspections, Appeals, and Licensing
6200 Park Ave., Des Moines, IA 50321

Hearing Aid Specialist – Temporary Permit
Schedule for Supervision Form

1. Name Temporary Permit Applicant: _____

2. Applicant's Address: _____

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

4. Name of Supervisor: _____Supervisor License #: _____

5. Supervisor's Business Name: _____

6. Supervisor's Business Address: _____

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

Supervision Schedule[i]

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

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

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

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

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

_____

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

_____

Supervision Complete Attestation

The supervision is complete and followed the training plan set forth above.

Temporary Permit Applicant's Signature: _____Date: _____

Supervisor's Signature: _____Date: _____

[i] To complete this supervision schedule, refer to the Competency Model in the IHS Study Guide and the requirements of Iowa Administrative Code 645—121.2 and 645—121.3.