NEW YORK STATE OF OPPORTUNITY.

Division of Licensing Services

New York State
**Department of State**
**Division of Licensing Services**
**Bureau of Educational Standards**
P.O. Box 22001
Albany, NY 12201-2001
(518) 486-3803
www.dos.ny.gov

# Hearing Aid Dispenser Continuing Education Course Approval Application

**PLEASE READ CAREFULLY, AS INCOMPLETE APPLICATIONS WILL BE RETURNED.**

- All applications must be submitted **60 DAYS BEFORE** the proposed course is to be conducted.
- The non-refundable fee of **$25** must accompany this original, signed application (photocopies will not be accepted). Fees may be paid by check or money order (made payable to the Department of State) or by MasterCard or Visa, using the enclosed credit card authorization form. Do not send cash.
- A non-refundable fee of **$25** must be submitted for each additional location.
- Annual registration period runs from January 1st through December 31st.
- **Attach to application: a detailed course outline with time sequence and other items listed on the back of this application.**

**1. WHAT IS THE TITLE AND LENGTH OF THIS COURSE? (There is a minimum of 1 hr. of instruction and a maximum of 20 hrs. of instruction.)**

Title _____ Hours _____

Check below if this course is being submitted to satisfy either of the following topic requirements:

☐ Infection Control ☐ NY State or Federal Law, Regulations, Professional Conduct

**2. EDUCATIONAL ORGANIZATION DATA**

SCHOOL NAME

ADDRESS (NUMBER AND STREET; ROOM/SUITE DESIGNATION)

CITY STATE ZIP+4

E-MAIL ADDRESS (IF ANY)

COORDINATOR'S NAME (person authorized to submit application on behalf of entity and responsible for administering Department of State regulations) TELEPHONE

( )

E-MAIL ADDRESS (IF ANY)

***DOES THIS INDIVIDUAL HOLD A NEW YORK HEARING AID DISPENSER LICENSE?*** ☐ **YES** ☐ **NO**

HOME ADDRESS (NUMBER AND STREET) TELEPHONE

( )

CITY STATE ZIP+4

**3. PRIMARY COURSE LOCATION**

LOCATION ADDRESS (PLACE, NUMBER AND STREET; ROOM/FLOOR/SUITE DESIGNATION)

CITY STATE ZIP+4

**4. SECONDARY LOCATIONS (Each location requires an additional fee of $25)**

LOCATION ADDRESS (PLACE, NUMBER AND STREET; ROOM/FLOOR/SUITE DESIGNATION)

CITY STATE ZIP+4

LOCATION ADDRESS (PLACE, NUMBER AND STREET; ROOM/FLOOR/SUITE DESIGNATION)

CITY STATE ZIP+4

***OUT OF STATE LOCATIONS***: All out-of-state locations must be provided on a separate sheet. No fee is required for these locations.

FOR OFFICE USE ONLY CODE #:_____ EFFECTIVE DATE: ___/___/___ EXPIRATION DATE: ___/___/___ ENTERED: ___/___/___ BY: _____

FEE RECEIVED: _____ TO REVENUE: ___/___/___ APPROVAL MAILED: ___/___/___ RECEIPT #: _____

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**5. TYPE OF EDUCATIONAL ORGANIZATION OWNERSHIP**

Is this organization an accredited College or University? ☐ Yes ☐ No* If No*, Please complete one of the following:

**INDIVIDUAL:** (Please submit a certified copy of the Trade Name Certificate and complete the following for Owner.)

NAME | HOME ADDRESS (NUMBER AND STREET)

CITY | STATE | ZIP+4

**PARTNERSHIP: (**Please submit a copy of Partnership Agreement and complete the following for all Partners.)

NAME | HOME ADDRESS (NUMBER AND STREET)

CITY | STATE | ZIP+4

NAME | HOME ADDRESS (NUMBER AND STREET)

CITY | STATE | ZIP+4

**CORPORATION:** (Please submit a copy of the Certificate of Incorporation and complete the following for all officers and other individuals who own 5% or more of the stock of this corporation. If needed, attach additional sheets.)

NAME | HOME ADDRESS (NUMBER AND STREET)

CITY | STATE | ZIP+4

NAME | HOME ADDRESS (NUMBER AND STREET)

CITY | STATE | ZIP+4

NAME | HOME ADDRESS (NUMBER AND STREET)

CITY | STATE | ZIP+4

**6.** Has any owner, partner, owner of 5% or more of the stock of the entity, or individual authorized to submit this application on behalf of the entity been convicted of any crime or offense, other than a minor traffic violation?

☐ **Yes*** ☐ **No** **If Yes*, submit a certified copy of each conviction.**

**7.** Has any license or permit issued to, applied for by any owner, partner, holder of 5% or more of the stock of the entity, or individual authorized to submit this application on behalf of the entity, been denied, suspended or revoked by this state or elsewhere by any other government or regulatory body?

☐ **Yes** ☐ **No** **If Yes, please provide details.**

**Course Instructors:** All instructors of approved courses must be approved with the Department of State. Applications for hearing aid dispenser instructor approval are available by request to the Division of Licensing Services, Bureau of Educational Standards. A one time evaluation and filing fee of $25 is required for each instructor's approval.

**8. COURSE CONTENT - ALL OF THE FOLLOWING MUST BE SUBMITTED:**

Å a detailed course outline with time sequence.

- a description of materials that will be distributed in the course.
- a listing of the books that will be utilized in the course.
- list of names and signatures of individuals authorized to sign certificates.

I subscribe and affirm under the penalties of perjury that the statements made in this application (including statements made in any accompanying papers) have been examined by me, and to the best of my knowledge and belief, are true and correct.

I understand that any misstatement made on this application for approval could result in an immediate revocation or withdrawal of the recognition of the approval of the entity by the Department of State.

*Coordinator Signature* X _____ *Date* _____

***A fee of $20 will be charged for any checks returned by a bank for insufficient funds.***