



# 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 Qualifying Course Approval Renewal Application

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

- » 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 a 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.
- » All instructors must be approved.

### PLEASE INDICATE THE COURSE CODE NUMBER FOR THE COURSE YOU WANT TO REGISTER.

CODE # D \_\_\_\_\_ CODE # CFY- \_\_\_\_\_

SCHOOL NAME \_\_\_\_\_

ADDRESS (NUMBER AND STREET; ROOM/SUITE DESIGNATION) \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP+4 \_\_\_\_\_

E-MAIL ADDRESS (IF ANY) \_\_\_\_\_

PRIMARY LOCATION (PLACE, NUMBER AND STREET; ROOM/FLOOR/SUITE DESIGNATION) \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP+4 \_\_\_\_\_

SECONDARY LOCATION #1 (PLACE, NUMBER AND STREET; ROOM/FLOOR/SUITE DESIGNATION) \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP+4 \_\_\_\_\_

SECONDARY LOCATION #2 (PLACE, NUMBER AND STREET; ROOM/FLOOR/SUITE DESIGNATION) \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP+4 \_\_\_\_\_

SECONDARY LOCATION #3 (PLACE, NUMBER AND STREET; ROOM/FLOOR/SUITE DESIGNATION) \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP+4 \_\_\_\_\_

Indicate names and signatures of persons authorized to sign course completion certificates.

PRINT NAME \_\_\_\_\_

SIGNATURE OF COORDINATOR \_\_\_\_\_

SIGNATURE \_\_\_\_\_

( )  
BUSINESS PHONE NUMBER \_\_\_\_\_

PRINT NAME \_\_\_\_\_

E-MAIL ADDRESS (if any) \_\_\_\_\_

SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

FOR OFFICE USE ONLY EFFECTIVE DATE: \_\_\_/\_\_\_/\_\_\_ EXPIRATION DATE: \_\_\_/\_\_\_/\_\_\_ ENTERED: \_\_\_/\_\_\_/\_\_\_ BY: \_\_\_\_\_ LABEL [ ]

FEE RECEIVED: \_\_\_\_\_ TO REVENUE: \_\_\_/\_\_\_/\_\_\_ APPROVAL MAILED: \_\_\_/\_\_\_/\_\_\_ RECEIPT #: \_\_\_\_\_

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