



Application Checklist for Hearing Aid Dispensers

Written Exam Only

If you need assistance, please email the Board at
speechandhearing@dca.ca.gov

1. Application

- Please remember to submit a 2x2 passport quality photograph.
- This application also contains the Written Exam Application.

2. Fees

- Please submit a check or money order to the Board in the amount of \$300.00, made payable to SLPAHADB. The application fee is \$75 and the written exam fee is \$225.

3. Fingerprints

- Applicants in California are required to use Live Scan for fingerprinting; please submit a copy of the completed form to the Board. Fees are paid directly to the Live Scan operator.
- All out-of-state applicants are required to submit two fingerprint cards (FD-258) and a check or money order to the Board for \$49.00 (DOJ and FBI processing fee). You may request fingerprint cards be mailed to you via email at speechandhearing@dca.ca.gov
 - Please note: one (1) check or money order in the amount of \$349 (\$300 application and written exam fee and \$49 fingerprint processing fees) may be submitted. Please make or money order payable to SLPAHADB.



HEARING AID DISPENSER INITIAL LICENSE APPLICATION APPLICANT/WRITTEN EXAM – NO LICENSE

\$300.00

(Application Fee \$75 + Written Exam Fee \$225)

INSTRUCTIONS: Do not print this application double-sided. Any corrections to this form must be crossed out and initialed.

IMPORTANT INFORMATION: This pathway to licensure requires you to pass both the California written and practical exams to obtain your permanent license. You are not allowed to work without a license. The passing of the written exam is required prior to taking the practical exam.

PART A – Applicant Information

1. FULL LEGAL NAME:	LAST	FIRST	MIDDLE
2. OTHER NAMES YOU HAVE USED (INCLUDING MAIDEN):			
3. STREET ADDRESS:			
CITY, STATE, ZIP CODE:			
4. RESIDENCE TELEPHONE:			
5. SOCIAL SECURITY NUMBER (SSN) OR INDIVIDUAL TAX IDENTIFICATION NUMBER (ITIN):			
6. DATE OF BIRTH: (MM/DD/YYYY)			
7. EMAIL ADDRESS:			
8. ARE YOU, A SPOUSE, OR DOMESTIC PARTNER OF AN ACTIVE DUTY MILITARY PERSONNEL? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, you may qualify for expedited application processing. An applicant for expedited application processing must meet the following requirements: 1) provide evidence that the applicant is married to, or in a domestic partnership or other legal union with, an active duty member of the Armed Forces of the United States who is assigned to a duty station in California under official active duty orders and; 2) hold a current license in another state, district, or territory of the United States in hearing aid dispensing.			
9. ARE YOU AN HONORABLY DISCHARGED VETERAN OF THE ARMED FORCES? Yes <input type="checkbox"/> NO <input type="checkbox"/> If yes, you may qualify for expedited application processing. An applicant for expedited application processing must meet the following requirement: 1) supply satisfactory evidence to the Board that the applicant has served as an active duty member of the Armed Forces of the United States and was honorably discharged.			

ATTACH 2" x 2"
PASSPORT QUALITY
PHOTOGRAPH
(Must be an actual
photograph, not a paper
copy.)

Photographs must be taken
within 60 days of the filing date
of this application.

Print your full name on the back
of the photograph.

PART A – Continued

A YES answer to any of the questions below (11 through 16), requires you to complete and submit the Conviction and Discipline Reporting Form.		YES	NO
10. Have you ever been the subject of a disciplinary action or have any <i>pending</i> disciplinary action taken or charges filed against any speech-language pathology, audiology, hearing aid dispensing, or other healing arts license? Include any disciplinary action taken by any other state or federal government entity? <i>This includes, but is not limited to, suspension, revocation, probation, confidential discipline, consent order, letter of reprimand or warning, or any other restriction of actions taken against a license.</i>		<input type="checkbox"/>	<input type="checkbox"/>
11. Have you had any pending investigations by any State or Federal agencies against you?		<input type="checkbox"/>	<input type="checkbox"/>
12. Have you been denied a license to practice speech-language pathology, audiology, hearing aid dispensing, or other healing arts, in any state or country?		<input type="checkbox"/>	<input type="checkbox"/>
13. Have you voluntarily surrendered a license to practice speech-language pathology, audiology, hearing aid dispensing, or other healing arts in another state or country?		<input type="checkbox"/>	<input type="checkbox"/>
14. Have you been convicted of, or pled nolo contendere to any criminal offense, misdemeanor or felony of any state, the United States, its territories or a foreign country? <i>(This includes any citation, infraction, misdemeanor and/or felony, excluding violations of minor traffic laws not involving alcohol or drugs which result in fines of \$300 or less. Note: Convictions that were later dismissed pursuant to Sections 1203.4, 1203.4a, or 1203.41 of the California Penal Code or equivalent non-California law must be disclosed. Convictions that were adjudicated in the juvenile court or convictions under California Health and Safety Code Sections 11357(b), (c), (d), (e), or Section 11360(b) that are two years or older should not be reported).</i> <i>You must also submit a certified copy of any court order dismissing a conviction pursuant to Penal Code Sections 1203.4, 1203.4a, or 1203.41.</i>		<input type="checkbox"/>	<input type="checkbox"/>
15. Are you required to register as a sex offender pursuant to Section 290 of the Penal Code, or the equivalent in another state or territory, or military or federal law?		<input type="checkbox"/>	<input type="checkbox"/>

PART B – Declaration of Education

16. NAME OF HIGH SCHOOL ATTENDED		YEAR GRADUATED OR YEAR PASSED GED	
17. NAME OF COLLEGE ATTENDED	YEAR GRADUATED OR UNITS ACHIEVED	DEGREE AWARDED	

PART C – Professional Data**YES****NO**

18. Are you an audiologist licensed to practice in California? If yes, please provide license number:	<input type="checkbox"/>	<input type="checkbox"/>
19. Are you a physician licensed to practice in California? If yes, please provide license number:	<input type="checkbox"/>	<input type="checkbox"/>
20. What state(s) have you previously been licensed to dispense hearing aids? Please provide verification from each state. Use additional page if needed. State: _____ License Number: _____ Date Issued: _____ Current status of license: Active Inactive Suspended Revoked Other		
21. Have you ever held or applied for a temporary or permanent license in California? If yes, please list when and under what name.	<input type="checkbox"/>	<input type="checkbox"/>

I hereby certify under penalty of perjury under the laws of the State of California that all statements made herein are true in every respect and that misstatements or omissions of material facts may be cause for denial of this application, or for suspension or revocation of a license.

APPLICANT'S SIGNATURE: _____ DATE SIGNED: _____

Notice: Effective July 1, 2012, the State Board of Equalization and the Franchise Tax Board may share taxpayer information with the Board. You are obligated to pay your state tax obligation and your license may be suspended if your tax obligation is not paid.



WRITTEN EXAM APPLICATION FOR DISPENSING

\$225

(Non-refundable)

INFORMATION:

1. Once the Board has processed your application, the contracted testing agency, PSI, will mail the instructions on how to schedule the written exam. Please allow 4-6 weeks for their notification. You may go to their website, psiexams.com, and download the PSI Candidate Information Bulletin.
2. The California Hearing Aid Dispensing written exam is given six days per week at 13 locations throughout California.
3. Immediately upon completion of the exam, you will be given your results. If you have passed, you will be given an application to apply for the practical exam. If you fail the written exam and choose to retake the exam, you must contact the Board for a re-examination application.

1. FULL LEGAL NAME:	LAST	FIRST	MIDDLE
2. OTHER NAMES YOU HAVE USED (INCLUDING MAIDEN):			
3. STREET ADDRESS:			
CITY, STATE, ZIP CODE:			
4. RESIDENCE TELEPHONE:			
5. DATE OF BIRTH			
6. EMAIL ADDRESS			

I hereby certify under penalty of perjury under the laws of the State of California that all statements made herein are true in every respect and that misstatements or omissions of material facts may be cause for denial of this application, or for suspension or revocation of a license.

APPLICANT'S SIGNATURE: _____ DATE SIGNED: _____

REQUEST FOR LIVE SCAN SERVICE

Applicant Submission

ORI: A0437 Type of Application: (check one) Employment ☒ License, Certification, Permit ☐ Volunteer
Code assigned by DOJ
Job Title or Type of License, Certification or Permit: Speech Pathologist Audiologist Speech Assistant Speech Aide Audiology Aide

PLEASE CIRCLE ONE

Agency Address Set Contributing Agency:

SPEECH-LANGUAGE PATHOLOGY & AUDIOLOGY & HEARING AID DISPENSERS BOARD

06187

Agency authorized to receive criminal history information

Mail Code (five-digit code assigned by DOJ)

2005 Evergreen Street, Suite 2100

N/A

Street No.

Street or PO Box

Contact Name (Mandatory for all school submissions)

Sacramento

CA

95815

()

City

State

Zip Code

Contact Telephone No.

Name of Applicant:

(Please print)

Last

First

MI

AKA's:

Last

First

CDL No.

DOB: _____ SEX: Male Female

Misc. No. BIL - Applicant Must Pay At Site

Agency Billing Number (if applicable)

HT: _____ WT: _____

Misc. No. _____

EYE Color: _____ HAIR Color: _____

Home Address: (Applies only if Youth Org/HRA or Public Utility submission)

POB: _____

Street or PO Box

SOC: _____

City, State and Zip Code

Your Number: 7700 SLP/AU

OCA No. (Agency Identifying No.)

Level of Service

DOJ ☒

FBI ☒

If resubmission, list Original ATI No. _____

Employer: (Additional response for Department of Social Services, DMV/CHP licensing, and Department of Corporations submissions only)

THIS SECTION IS NOT APPLICABLE

Employer Name

Street No.

Street or PO Box

Mail Code (five digit code assigned by DOJ)

City

State

Zip Code

()

Agency Telephone No. (Optional)

Live Scan Transaction Completed By: _____

Name of Operator

Date _____

Transmitting Agency

ATI No.

Amount Collected/Billed

REQUEST FOR LIVE SCAN SERVICE

Applicant Submission

ORI: A0437 Type of Application: (check one) ☐ Employment ☒ License, Certification, Permit ☐ Volunteer
Code assigned by DOJ
Job Title or Type of License, Certification or Permit: Speech Pathologist Audiologist Speech Assistant Speech Aide Audiology Aide
PLEASE CIRCLE ONE

Agency Address Set Contributing Agency:

**SPEECH-LANGUAGE PATHOLOGY & AUDIOLOGY &
HEARING AID DISPENSERS BOARD**

06187

Agency authorized to receive criminal history information

Mail Code (five-digit code assigned by DOJ)

2005 Evergreen Street, Suite 2100

N/A

Street No.

Street or PO Box

Contact Name (Mandatory for all school submissions)

Sacramento

CA

95815

City

State

Zip Code

()

Contact Telephone No.

Name of Applicant: _____
(Please print) Last First MI

AKA's: _____
Last First

CDL No. _____

DOB: _____ SEX: Male Female

Misc. No. **BIL - Applicant Must Pay At Site**
Agency Billing Number (if applicable)

HT: _____ WT: _____

Misc. No. _____

EYE Color: _____ HAIR Color: _____

Home Address: (Applies only if Youth Org/HRA or Public Utility submission)

POB: _____

Street or PO Box

SOC: _____

City, State and Zip Code

Your Number: _____
OCA No. (Agency Identifying No.)

Level of Service DOJ ☒ FBI ☒

If resubmission, list Original ATI No. _____

Employer: (Additional response for Department of Social Services, DMV/CHP licensing, and Department of Corporations submissions only)

THIS SECTION IS NOT APPLICABLE

Employer Name

Street No.

Street or PO Box

Mail Code (five digit code assigned by DOJ)

()

Live Scan Transaction Completed By: _____ Date _____
Name of Operator

Transmitting Agency

ATI No.

Amount Collected/Billed

REQUEST FOR LIVE SCAN SERVICE

Applicant Submission

ORI: A0437 Type of Application: (check one) ☐ Employment ☐ License, Certification, Permit ☐ Volunteer
Code assigned by DOJ
Job Title or Type of License, Certification or Permit: Speech Pathologist Audiologist Speech Assistant Speech Aide Audiology Aide

PLEASE CIRCLE ONE

Agency Address Set Contributing Agency:

SPEECH-LANGUAGE PATHOLOGY & AUDIOLOGY & HEARING AID DISPENSERS BOARD

06187

Agency authorized to receive criminal history information

Mail Code (five-digit code assigned by DOJ)

2005 Evergreen Street, Suite 2100

N/A

Street No.

Street or PO Box

Contact Name (Mandatory for all school submissions)

Sacramento

CA

95815

()

City

State

Zip Code

Contact Telephone No.

Name of Applicant:

(Please print)

Last

First

MI

AKA's:

Last

First

CDL No.

DOB:

SEX:

Male

Female

Misc. No.

BIL - Applicant Must Pay At Site

Agency Billing Number (if applicable)

HT:

WT:

Misc. No.

EYE Color:

HAIR Color:

Home Address: (Applies only if Youth Org/HRA or Public Utility submission)

POB:

Street or PO Box

SOC:

City, State and Zip Code

Your Number:

7700 SLP/AU

OCA No. (Agency Identifying No.)

Level of Service

DOJ ☒

FBI ☒

If resubmission, list Original ATI No.

Employer:

(Additional response for Department of Social Services, DMV/CHP licensing, and Department of Corporations submissions only)

THIS SECTION IS NOT APPLICABLE

Employer Name

Street No.

Street or PO Box

Mail Code (five digit code assigned by DOJ)

City

State

Zip Code

Agency Telephone No. (Optional)

Live Scan Transaction Completed By:

Name of Operator

Date

Transmitting Agency

ATI No.

Amount Collected/Billed