Wisconsin Department of Safety and Professional Services

Office Location: 4822 Madison Yards Way
Madison, WI 53705
Phone Number: (608) 266-2112

LicensE Portal: https://license.wi.gov/
Email: dsps@wisconsin.gov
Website: http://dsps.wi.gov

HEARING AND SPEECH EXAMINING BOARD

HEARING INSTRUMENT SPECIALIST TEMPORARY TRAINEE PERMIT REQUEST

APPLICANT: Complete this section and submit directly to your supervisor for completion. Form must be returned directly from the supervisor to the Department.

Last Name	First Name	MI	Former / Maiden Name(s)

Temporary Trainee Permit Fee: $10.00 permit fee is required. Applicant must pay permit fee online via applicant's LicensE account.

Application Number

I hereby make application for a temporary trainee permit to sell or fit hearing aids in the following location:

Agency/Department/Employer:	
Name of Physical Work Location:	
Address of Physical Work Location: (number/street, city, state, zip code)	
Daytime Phone Number:	

I would like to be scheduled to write the Hearing Instrument Specialist examination on: _____/ _____/ _____ (mm/dd/yyyy).

I understand that a trainee permit may entitle me to practice fitting of hearing aids for a period of one (1) year. A trainee may request, via a written petition to the Board, a one (1) year extension due to extenuating circumstances. Petitions are reviewed by the Board on a case-by-case basis. Board approval of an extension request is not guaranteed.

ATTESTATION OF APPLICANT: I declare that I am the person referred to on this form and that all information required to be completed by me (the applicant for a credential), is complete and accurate to the best of my knowledge and belief. Furthermore, I declare that after completing the information that was required by me (and only that information) the form was forwarded to the relevant third-party for completion of the information asked of them. I also declare that to the best of my knowledge the completed form was provided to the Department of Safety and Professional Services by the relevant third-party (and not by me, the applicant). Finally, I declare that I understand that failure to provide the requested information, making any materially false statement and/or giving any materially false information in connection with my application for a credential may result in credential application processing delays; denial, revocation, suspension, or limitation of my credential; or any combination thereof; or such other penalties as may be provided by law. By signing below, I am signifying that I have read and understand the above declarations. I hereby authorize the school/course provider named below to provide the Department with the information requested below. I hereby authorize the school named below to provide the Department with the information requested below. I hereby authorize the Commission on Dietetic Registration to provide the Department with the information requested below.

Applicant Signature (If unable to provide a digital signature, please print and sign form.)	**Date** (mm/dd/yyyy)
	_____/ _____/ _____

Continued on next page.

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SUPERVISOR: Complete this section for the above-named applicant and return directly to the Department using the LicensE Third Party* Upload Portal at license.wi.gov. You will need the application number shown above. (*For form completion purposes, the term "Third-Party" refers to any non-applicant or non-DSPS individual or entity submitting required documentation in support of a credential application.)

AFFIDAVIT: I request that a temporary trainee permit to sell or fit hearing aids be issued to the above named individual for practice in the above listed establishment and location. I certify that I hold a valid hearing instrument specialist or a valid audiologist license issued under Wis. Stat. ch. 459 and that I shall be responsible for his/her direct supervision and training, being physically present as the law requires and that I shall be liable for all negligent acts and omissions of the applicant in the fitting of hearing aids. I understand that the trainee permit will be revoked by the Board upon receipt of my signed statement that I wish to cease supervising such trainee (Wis. Admin. Code ch. HAS 2 and Wis. Stat. § 459.07).

ATTESTATION OF THIRD-PARTY PROVIDING INFORMATION RELATED TO APPLICANT: I declare, on behalf of the third-party asked to provide information related to the applicant identified on this form, that the information provided is true and correct to the best of my knowledge and belief. I further declare that after completing the form I, or other third-party staff, will provide the completed form directly to the Wisconsin Department of Safety and Professional Services for review. By signing below, I am signifying that I have read, understand, and have complied with the above declarations.

Signature of Supervisor (If unable to provide a digital signature, print and sign form.)	**Date** (mm/dd/yyyy)
	_____/ _____ / _____
Printed Name of Supervisor	**Title of Supervisor**
Wisconsin License Number	**Phone**