Application for Certification as a Hearing Instrument Dispenser

This notice is given pursuant to Minnesota Statutes, sections 13.04, subdivision 2 and 13.41, subdivision 2. The Commissioner of the Minnesota Department of Health (Commissioner) will use information provided in this application to determine whether you meet the requirements of Minnesota Statutes sections 153A.13 through 153A.20, 148.5195, 148.5197 and 148.5198 for hearing instrument dispenser certification. You are not legally required to supply the requested information. However, FAILURE TO PROVIDE INFORMATION OR SUBMISSION OF FALSE OR MISLEADING INFORMATION MAY DELAY THE PROCESSING OF YOUR APPLICATION OR MAY BE GROUNDS FOR DENYING YOUR APPLICATION. All data, except your name and address, submitted by you or on your behalf are considered private until you are certified. Once you become certified, all application data except your Social Security Number and non-designated address become public and will be released to anyone upon request. Information in your application may, in some circumstances, be disclosed to other persons or entities including: other Minnesota Department of Health staff, the Hearing Instrument Dispenser Advisory Council, the Minnesota Attorney General's Office, and any person to whom the Commissioner must refer your application for verification or to otherwise determine your qualifications. Application data may also be disclosed to an appropriate person or agency to prevent a clear and present danger. If you contest the Commissioner's Decision regarding your certification, resulting in a contested case hearing or litigation, your application data becomes accessible to the Minnesota Office of Administrative Hearings, appropriate courts, and those associated with such proceedings, and may become accessible to the public.

Application Instructions

Applicants for certification must have passed the Minnesota Hearing Instrument Dispenser Examination. You must answer every numbered question or statement in this application. If something does not apply to you, please write "N/A" in the space provided for a response. Incomplete applications will be returned. Each question in this application must be answered fully, truthfully, and accurately by the applicant. Intentionally submitting false or misleading information to the commissioner is cause for denial of certification or disciplinary action by the commissioner. If space for any answer is insufficient, the answer may be completed on page 8 of this application. If additional sheets of paper are used, please specify the number of the question, sign each page and attach to the application.

ALL APPLICANTS MUST INCLUDE THE FOLLOWING AS PART OF THE APPLICATION OR IT WILL BE CONSIDERED INCOMPLETE.

1. Completed, signed and dated application.
2. Signed and dated Records Waiver Authorization and Release.
3. Certification of Calibration of Audiometric Equipment.
4. Check or money order payable to the Minnesota Department of Health in the proper amount for your initial certification fee and surcharge fee. The fee schedule is on page 6 of this application. **Fees are nonrefundable.**

Qualifications for HID Certification

PLEASE PRINT LEGIBLY IN BLUE INK

1. I am 21 years of age or older? ☐ Yes ☐ No (If no, you may not obtain certification)

2. I have successfully completed the Minnesota Hearing Instrument Dispenser (HID) Examination.
   ☐ Yes, Date:_____ ☐ No (If no, you must take before applying)

_____

Last Name First Name Middle

_____

Home Address City State ZIP

_____

Home Phone Work Phone

_____

Email Address

_____

Social Security Number ☐Male ☐ Female Date of Birth (MM/DD/YYY)
(This information is required by Minn. Stat. sec. 270C.72, Subd. 4.)

3. Have you ever used another name under which records may be filed concerning your application, including your education, training or experience? ☐ Yes ☐ No

   If yes, please list name(s) used:

   _____

   _____

4. Are you self-employed? ☐ Yes ☐ No. If yes, please list current business name(s), address (es) and telephone number(s). Include street address, city state and zip code. A post office (P.O.) box is not sufficient. Include area code on all phone numbers supplied. Identify all business names used if business has more than one name. Attach additional sheets if needed.

   Business Name _____

   Address (City, State, Zip) _____

   Phone Number(s) _____

_____

Name of applicant's employer

_____

All business names used by employer

_____

Employer's Address

_____

Name of Applicant's Supervisor or Manager

_____

Supervisor's or Manager's Address Phone Number

5. Do you conduct business out of your home? ☐ Yes ☐ No

Background Questions

Important address information – Please mark the address at which you would like to receive correspondence from the Minnesota Department of Health: ☐ Home ☐ Employer

Please note that this address will be disclosed to anyone requesting it pursuant to Minnesota Statutes, § 13.41, subd. 2.

6. Business name(s) and address (es) under which your hearing instrument dispensing and activities directly related to hearing instrument dispensing took place in the last three years.

   Include your trainee status, if any. Provide the dates, by month, day and year that are applicable to the names and addresses provided. Attach additional sheets if necessary.

   Business Name _____

   Address (City, State, Zip) _____

   Phone Number(s) _____

   MM/DD/YYYY-MM/DD/YYYY_____

7. Have you ever worked for or had an ownership interest in, a hearing aid dispensing company which ceased operations? ☐ Yes ☐ No Attach additional sheets if necessary.

   If yes, what was the name of the company and the year it ceased operations?

   _____

8. Please describe hearing instrument dispensing education and training you have had? (Please provide dates by the month, day and year).

   _____

9. Do you now hold or have you ever been issued a permit, registration, license or other credential to dispense hearing instruments in another state? ☐ Yes ☐ No

   If yes, please identify the state(s), the current status, the date(s) of issuance and any identification number(s) used in relation to your permit, registration, license or other credential.

   State Current Status Date of Issuance I.D. Number

   _____

   _____

   _____

10. Is action being taken against you or has action ever been taken against you or your legal authorization to dispense hearing instruments in this or another state either through denial of application, revocation, suspension, restrictions, limitations, conditions, reprimand or any other means? (Include actions resulting in stipulation agreements). ☐ Yes ☐ No

    If yes, please explain the reason for the action, action taken, and name the state, address of credentialing authority in possession of record, dates, and party or parties involved in the action.

    _____

    _____

11. For each state in which you hold or have ever been issued a permit, registration, license or other credential to dispense hearing instruments, you must submit a letter from the appropriate person in the state, which provides the following information: your name, date of birth, date of issuance of your credential, date of expiration of your credential, credential number, current status of your credential, and an affirmative statement about disciplinary action pending or taken against you, if any. You must send a verification of credential form to all states where you hold or have ever held a permit, registration, license or other credential to dispenser hearing aids. The form should be completed by the other jurisdiction and returned to you in a sealed/unopened envelope. This sealed/unopened envelope must be sent to our office with your application and the application fee.

    If the state licensing agency will only send electronic verification(s) please request that they send the verification to health.hid@state.mn.us. Please indicate below the name(s) of the state licensing agency and provide the date(s) that you requested the electronic verification(s).

    Name of State Licensing Agency:_____Date Verification Requested:_____

    Name of State Licensing Agency:_____Date Verification Requested:_____

12. Do you have any criminal charges pending against you? □ Yes □ No

    If yes, please attach a statement giving full details.

13. Have you been convicted, within the last five years, of a felony, gross misdemeanor or misdemeanor which relates to hearing instrument dispensing or which involved an essential element of which was dishonesty? □ Yes □ No

    If yes, attach a statement giving full details including the crime(s) of which you were convicted, date(s), name(s) and location of court(s) and case number(s). Please date and sign each page of the statement.

14. Do you have a physical or mental condition or chemical dependency that could affect your ability to engage in hearing instrument dispensing with reasonable judgment, skill or safety? □ Yes □ No

    If yes, please explain on attached statement.

15. Have you ever been disciplined under any of the current or previous Minnesota laws governing the sale of hearing aids? (Include actions resulting in stipulation agreements with the Commissioner of Health, Attorney General, Department of Human Services or other Authority). □ Yes □ No

16. Have you ever violated a state or federal court order or judgement issued to manage your activities in dispensing hearing instruments in this state or any other state? (Include conciliation court judgement.
    □ Yes □ No

17. Have you ever engaged in, or aided or abetted another in engaging in, or had someone act on your behalf in any of the following acts or conduct?

    a. □ Yes □ No – prescribed or otherwise recommended to a consumer or potential consumer the use of a hearing instrument, unless a prescription from a physician or recommendation from a hearing instrument dispenser or audiologist was in writing, was delivered to the consumer or potential consumer, and bore the following information in all capital letters of 12-point or larger bold-face type: **"THIS PRESCRIPTION OR RECOMMENDATION MAY BE FILLED BY, AND HEARING INSTRUMENTS MAY BE PURCHASED FROM, THE LICENSED AUDIOLOGIST OF CERTIFIED DISPENER OF YOUR CHOICE."**

    b. □ Yes □ No – failed to provide a copy of the audiogram, upon which the prescription or recommendation is based, to the consumer request.

    c. □ Yes □ No – failed to provide the consumer rights brochure required by Minnesota Statutes, Section 148.5197, subd.3.

    d. □ Yes □ No – presented advertising that was false or misleading.

e. ☐ Yes ☐ No – Provide the Commissioner of Health with false or misleading information.

f. ☐ Yes ☐ No – engaged in conduct likely to deceive, defraud, or harm the public or demonstrated a willful or careless disregard for health, welfare, or safety or a consumer.

g. ☐ Yes ☐ No – split fees or promised to pay a portion of a fee to any other professional other than a fee for services rendered by the other professional to the client.

h. ☐ Yes ☐ No – engaged in abusive or fraudulent billing practices, including violations of federal Medicare and Medicaid laws, Food and Drug Administration regulations, or state medical assistance laws.

i. ☐ Yes ☐ No – obtained money, property, or services from a consumer through the use of undue influence, high pressure sales tactics, harassment, duress, deception, or fraud.

j. ☐ Yes ☐ No – failed to comply with restriction on sales of hearing aids in Minnesota Statutes, Section 148.5198 (the 45-day refund law) and Chapter 153A, Section 153A.14, subd. 4 (illegal sales).

k. ☐ Yes ☐ No – performed the services of a hearing instrument dispenser in an incompetent or negligent manner.

l. ☐ Yes ☐ No – failed to comply with the requirements of Minnesota Statutes, Chapter 153A and Minnesota Statutes, Sections 148.511 through 148.5198 as an employer, supervisor or trainee.

m. ☐ Yes ☐ No – failed to provide information in a timely manner in response to a request by the Commissioner, Commissioner's designee or the Advisory Council.

n. ☐ Yes ☐ No – failed to cooperate in a good faith with the Commissioner, the Commissioner's designee, or the Advisory Council in any investigation.

o. ☐ Yes ☐ No – failed to perform hearing instrument dispensing with reasonable judgment, skill, or safety due to the use of alcohol or drugs, or other physical or mental impairment.

p. ☐ Yes ☐ No – failed to fully disclose actions taken against the applicant or the applicant's legal authorization to dispense hearing instruments in this or another state.

q. ☐ Yes ☐ No – have been or are being disciplined by the Commissioner of the Department of Health, or other authority, in this or another jurisdiction, if any of the grounds for the discipline are the same or substantially equivalent to those in Minnesota Statutes, Chapter 153A, Sections 153A.13 to 153A.19 and Minnesota Statutes, Sections 148.511 through 148.5198.

r. ☐ Yes ☐ No – misrepresented the purpose of hearing tests or in any way communicated that the hearing test or hearing test protocol required by Section 153A.14, subd. 4b, is a medical evaluation, a diagnostic hearing evaluation conducted by an audiologist, or is other than a test to select a hearing instrument, except that the hearing instrument dispenser can determine the need for or recommend the consumer obtain a medical evaluation consistent with requirements of the United States Food and Drug Administration.

If you answered yes to question(s) 11 through 17 please explain. Attach additional sheets if necessary.

_____

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_____

THE INFORMATION I HAVE PROVIDED IN THIS APPLICATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Signature Date

I HAVE READ, UNDERSTAND AND WILL ABIDE BY THE FEDERAL AND MINNESOTA STATUTES AND RULES GOVERNING HEARING INSTRUMENT DISPENSING.

Signature Date

Hearing Instrument Dispenser Fee Schedule

Please return the completed and signed application to the address listed below. The certification fee for new applicants is prorated based on the number of quarters remaining in the annual certification period. To determine your initial prorated fee amount, read across the top row in the table below to find the month your certification application will be received in our office. Applicants applying in September and October will not renew their certification until October of the following year, thus the amount shown is greater than the annual renewal fee indicated above. The fee includes the $22.50 surcharge for MDH to process the criminal background study as required by Minnesota Statues, section 153.17(e).

Fee Schedule January through June

Month	Jan	Feb	Mar	Apr	May	June
Fee	$586.50	$586.50	$398.50	$398.50	$398.50	$210.50

Fee Schedule July through December

Month	July	Aug	Sept	Oct	Nov	Dec
Fee	$210.50	$210.50	$772.50	$772.50	$772.50	$586.50

Mail Addresses

Minnesota Department of Health
Health Occupations Program
P.O. Box 64882
St. Paul, MN 55164-0882

Records Waiver Authorization and Release

I HEREBY AUTHORIZE THE COMMISSIONER OF THE MINNESOTA DEPARTMENT OF HEALTH OR the Commissioner's designee to obtain, and authorize the person to whom this authorization is presented to release, any and all information contained in the license, registration, permit or other credentialing records in this or any other state where I have dispensed or have authorization to dispense hearing instruments.

This authorization also allows the commissioner or the commissioner's designee to make summaries or photocopies of all or any portion of any records pertaining to my sale of or authorization to sell hearing instruments in this or any other state. A photocopy of this authorization may be considered as valid as the original.

Dated this _____day of _____ , 20_____.

_____

Signature

_____

Name Printed

_____

Permanent Address

_____

City State Zip

Certification of Calibration of Audiometric Equipment

I HEREBY CERTIFY and understand that any audiometric equipment that I use has been calibrated to the current ANSI standards within twelve (12) months of the date of this application. For purpose of this certification "ANSI" means ANSI S3.6 – 1989, American National Standard Specification for Audiometers from the American National Standards Institute.

_____

Signature

_____

Name Printed

_____

Permanent Address

_____

City State Zip

Additional Comments

Please use this page to complete answers only when there is insufficient space following the questions on the proceeding pages.

Question Number and Answer

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Signature required only when using this page to complete answers: _____

Minnesota Department of Health
PO Box 64882
St. Paul, MN55164-0882
651-201-4200
health.hid@state.mn.us
www.health.state.mn.us

05/29/2024

To obtain this information in a different format, call: 651-201-4200.