



STATE OF TENNESSEE  
TENNESSEE DEPARTMENT OF HEALTH  
OFFICE OF HEALTH LICENSURE AND REGULATION  
665 MAINSTREAM DR  
NASHVILLE, TN 37243  
[www.tn.gov/health](http://www.tn.gov/health)  
(800) 778-4123, ext. 741-5735 (615) 741-5735

**Application for Licensure as a Hearing Instrument Specialist**

This packet contains information relative to obtaining licensure as a hearing instrument specialist.

The requirements for application are supported by Council rules and regulations and T.C.A. 63-17-101 et seq. It is imperative that you read the instructions, rules and regulations, and statute carefully prior to applying. Application and examination fees are nonrefundable and all documents submitted to the Council become a part of your HIS file and are not returnable. Submission of an application is not a permit to participate in any testing or fitting for a hearing aid. The Council hereby gives warning that it has the power to verify all information provided within this application. Incomplete, misleading or inaccurate information could result in automatic denial of the application.

It is suggested that documents required in the instructions be requested upon receipt of the packet. Supporting documents requested in the instructions must be received in the Council administrative office within 30 days of receipt of your application. Upon initial review of your application, a deficiency letter will be sent to you by certified mail if your application is incomplete or the supporting materials have not arrived in this office. Upon notification of a deficiency, the file must be completed within 30 days or the file will be closed and you will be required to reapply. When the application is deemed "administratively complete" you will receive written instructions as to how to proceed to the next step toward licensure.

***PLEASE NOTE: Application review and processing time can take as long as 6-8 weeks from the date the application was received in our office. We will respond to questions regarding the status of an application by mail and remind you that excessive calls may delay the processing of applications. Every effort is made to keep you informed of the status of your file and to process your application in a timely, efficient manner.***

***You must put your social security number on this form for the application to be complete. State and federal law require social security numbers on this application. Tenn. Code Ann. §36-5-1301(a), as authorized by 42 U.S.C. §405 (c) (2)(C)(i). The number will be used to verify your identity, to ask questions about your financial responsibility, and for any other purpose allowed by state or federal law. When you provide your social security number on this application and sign the form, you are agreeing that the Department of Health may use your social security number in furtherance of federal and state law, for example, to collect delinquent fees.***

## INSTRUCTIONS

Read the instructions below which will assist you in completing the application and submitting exactly the items needed by the Council to determine your eligibility for licensure. *It is imperative that you read the instructions, rules and regulations, and statutes carefully prior to applying.*

1. Application must be typed or printed.
2. Fees. Make check or postal money order payable to the State of Tennessee. All fees are nonrefundable.
3. Official college transcript. It is the applicant's responsibility to request a transcript be submitted directly from the college/university to the Council Administrative office. The transcript must carry the official seal of the college. If your name has changed since you received the degree, please have the school reference both of your names.
4. Photograph. An original, recent (12 months) passport type.
5. A certified or notarized copy of the applicant's birth certificate or naturalization papers must accompany application.
6. Physician's Certification attesting to the fact that in his/her professional opinion you are free of contagious or infectious disease.
7. All applicants must complete the Declaration of Citizenship form and have it notarized. The form can be found at: <http://tn.gov/assets/entities/health/attachments/PH-4183.pdf>
8. Outline of Program of Supervision. Apprentice applicants must submit either (1) an original letter, on official stationery, from their sponsor or (2) the enclosed outline of program of supervision form. The information must include sponsor's name, business address, phone number, place you will be working, outline of your planned training (including hours you will be working), and a list of all study material you will be using while being supervised.
9. Out-of-State Verification. Verification from each state where you hold or have held a license as a hearing instrument specialist or license in any other profession. Reciprocity applicants must submit evidence that they have passed the IHS Examination. This evidence must be submitted to the council directly from the International Hearing Society.
10. A criminal Background Check is required for all methods of licensure. For instructions to obtain a criminal background check click here: <http://www.tn.gov/health/topic/CBC-check> .

Mail your application, fee and supporting materials to:

COUNCIL FOR LICENSING HEARING INSTRUMENT SPECIALISTS  
665 MAINSTREAM DR  
NASHVILLE TN 37243

Materials not addressed as indicated above may not reach the Council office thus delaying the application process for you. Whenever corresponding with the Council, always reference your name, profession, and Council.

From the date your application is mailed, please allow seven to ten (7-10) working days for the material to reach the Council office. "Overnight mail" is handled as "routine" mail by the Council office and requires the same time frame. **If mailing overnight, the zip code is 37228.**

**We will respond to questions regarding the status of an application by mail or email. Every effort is made to keep you informed of the status of your file and to process your application in a timely, efficient manner.**

**REMEMBER, SUBMISSION OF AN APPLICATION IS NOT A PERMIT TO PARTICIPATE IN ANY TESTING OR FITTING OF A HEARING AID.**

**Licensure Process - Includes the following steps, in sequence:**

1. Submit application, supporting documents, and fees to Council administrative office.
2. Application and supporting documents reviewed.
3. Written notification of eligibility or ineligibility to sit for IHS examination, if applicable.
4. Schedule for exam.
5. Written notification of exam results and eligibility or ineligibility to sit for practical examination.
6. Schedule to sit for next available exam.
7. Written notification of exam results and eligibility/ineligibility for licensure.

**APPRENTICE**

Qualifications:

1. At least 18 years of age
2. Education two (2) years of accredited college-level coursework
3. Free of contagious or infectious disease

Checklist - Identifies materials which constitute a complete application for HIS license by apprentice:

- \_\_\_ HIS Application (complete Attachment 1 also)
- \_\_\_ Fees (\$135.00)
- \_\_\_ Official college transcript sent to the Council directly from the educational institution.
- \_\_\_ Photograph, passport size.
- \_\_\_ Notarized Copy of Birth certificate or naturalization papers
- \_\_\_ Document that changed your name (Marriage certificate, divorce decree, court order), IF APPLICABLE
- \_\_\_ Notarized Declaration of Citizenship form found at:  
<http://tn.gov/assets/entities/health/attachments/PH-4183.pdf>
- \_\_\_ A criminal Background Check is required for all methods of licensure. For instructions to obtain a criminal background check click here: <http://www.tn.gov/health/topic/CBC-check> .
- \_\_\_ Physicians certification

## HEARING INSTRUMENT SPECIALIST BY UPGRADE FROM APPRENTICE

### Qualifications

Holds a current Tennessee apprentice license

Checklist - Identifies materials which constitute a complete HIS by upgrade from apprentice file.

- \_\_\_ Application
- \_\_\_ Affidavit from supervisor that training has been completed, including 60 hours of classroom training
- \_\_\_ Fees (\$635.00)

## HEARING INSTRUMENT SPECIALIST BY RECIPROCITY

### Qualifications

Must be at least 18 years of age

1. Education two (2) years of accredited college-level coursework
2. Free of contagious or infectious disease
3. Original license must have been issued based on passing score as determined by the IHS.

Checklist - Identifies materials which constitute a complete HIS application by reciprocity.

- \_\_\_ Application form
- \_\_\_ Fees (\$635.00)
- \_\_\_ Official college transcript sent to the Council directly from the educational institution.
- \_\_\_ Photograph, original, passport size.
- \_\_\_ Birth certificate or naturalization papers
- \_\_\_ Notarized Declaration of Citizenship form found at:  
<http://tn.gov/assets/entities/health/attachments/PH-4183.pdf>
- \_\_\_ Document that changed your name (Marriage certificate, divorce decree, court order), IF APPLICABLE
- \_\_\_ A criminal Background Check is required for all methods of licensure. For instructions to obtain a criminal background check click here: <http://www.tn.gov/health/topic/CBC-check> .
- \_\_\_ Physician's Certification
- \_\_\_ Verification of licensure from each state where you hold or have held a license. **Must include practical exam scores.**
- \_\_\_ Verification submitted directly from IHS of exam scores

**IF YOUR LICENSE WAS NOT BASED ON THE ABOVE, YOU WILL NOT QUALIFY FOR LICENSURE BY RECIPROCITY AND WILL NEED TO FILE AN APPLICATION FOR LICENSURE BY EXAMINATION!**

## HEARING INSTRUMENT SPECIALIST BY EXAMINATION

### Qualifications

1. At least 18 years of age
2. Education two (2) years of accredited college-level coursework
3. Free of contagious or infectious disease

Checklist – Identifies materials which constitute a complete HIS application by Examination.

- \_\_\_ Application form
- \_\_\_ Fees (\$635.00)
- \_\_\_ Official college transcript sent to the Council directly from the educational institution.
- \_\_\_ Photograph, original, passport size.
- \_\_\_ Birth certificate or naturalization papers
- \_\_\_ Notarized Declaration of Citizenship form found at:  
<http://tn.gov/assets/entities/health/attachments/PH-4183.pdf>
- \_\_\_ Document that changed your name (Marriage certificate, divorce decree, court order), IF APPLICABLE
- \_\_\_ A criminal Background Check is required for all methods of licensure. For instructions to obtain a criminal background check click here: <http://www.tn.gov/health/topic/CBC-check> .
- \_\_\_ Physician's Certification

### IHS EXAMINATION INFORMATION

1. Study guides may be obtained by visiting the following website: [www.webassessor.com/ihs](http://www.webassessor.com/ihs).
2. Upon being deemed eligible, your information will be submitted to IHS, who will then contact you by email, to advise you how to schedule the exam, and to send you a copy of the Study Guide.
3. After you take the exam, IHS will notify the Board administrative office of the results. Examination results will then be mailed to you, with additional information to advise you of your next step in the licensing process. PLEASE NOTE: **Examination results are not provided by telephone.**

### GENERAL APPLICATION INFORMATION

1. Application review and processing can take 4-6 weeks from the date your application was received. Please do not call or email to check the status of your application, as this will only delay the review process. You will be notified in writing, by mail or email, of any missing information.
2. Application deadline. Statute requires that your application and all supporting materials be in the Council's administrative office 45 days prior to the examination date. If your materials are received and your file is complete you will receive a response as to eligibility/ineligibility for the next scheduled IHS written examination.
3. Files which are incomplete on the application deadline date will be reviewed during the next review cycle. THERE ARE NO EXCEPTIONS! Please consider this fact when planning your submission and allow a minimum of two weeks to correct any deficiencies. If a deficiency is discovered during the preliminary review, written notification will be sent to you by mail or email.



Are you a member of the U.S. armed forces who has, within the preceding 180 days, retired from the armed forces, received any discharge other than a dishonorable discharge from the armed forces, or been released from active duty to a reserve component of the armed forces? (If yes, please provide proof of status.)

Yes \_\_\_\_ No \_\_\_\_

Are you the spouse of a member of the armed forces who has been transferred by the military to Tennessee or who has, within the preceding 180 days, retired from the armed forces, received a discharge other than a dishonorable discharge from the armed forces or been released from active duty to a reserve component? (If yes, please provide proof of same.)

Yes \_\_\_\_ No \_\_\_\_

Have you ever been known by any other names besides what is listed above? Yes \_\_\_\_ No \_\_\_\_

If yes, please state in full every other name by which you have been known, the reason therefore, and inclusive dates so known: \_\_\_\_\_

\_\_\_\_\_

**EDUCATION**

Name and location of college/university from which you hold a certificate or degree, or two years of college coursework. Please have a transcript sent directly to the Council for Licensing Hearing Instrument Specialists

SCHOOL: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY/STATE/ZIP: \_\_\_\_\_

DEGREE RECEIVED: \_\_\_\_\_ DATE DEGREE RECEIVED: \_\_\_\_\_

DATES ATTENDED: \_\_\_\_\_

**EMPLOYMENT**

Please complete your entire healthcare employment history starting with the most current position first. Use the back of [this page](#), if you need additional space. Dates of employment must be included.

<u>Company/ Employer:</u>	<u>Address:</u> (City, and State)	<u>Position:</u>	<u>Duties:</u>	<u>Dates</u>	
				<u>From:</u> <u>Mo./Yr.</u>	<u>To:</u> <u>Mo./Yr.</u>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Do you engage in private practice? Yes \_\_\_\_ No \_\_\_\_ If yes, give location:

\_\_\_\_\_

\_\_\_\_\_

**LICENSURE INFORMATION**

**Yes      No**

Are you or have you ever been licensed in this profession in another state? \_\_\_\_\_ \_\_\_\_\_

Are you or have you ever been licensed in any other profession in Tennessee or another state? \_\_\_\_\_ \_\_\_\_\_

List below **ALL STATES, COUNTRIES, OR PROVINCES IN WHICH YOU HAVE EVER BEEN OR ARE CURRENTLY LICENSED, PERMITTED, OR CERTIFIED.** Additional pages may be added if necessary. Request that verification of licensure be submitted directly to the Board’s Office from each state.

STATE	PROFESSION	LICENSE NUMBER	CURRENT STATUS
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**COMPETENCY INFORMATION**

**PLEASE ANSWER THE FOLLOWING QUESTIONS.** If you answer “yes” to any of the questions in this part, you must supplement your affirmative response with a thorough explanation on a separate page. **IN SUPPORT OF YOUR EXPLANATION, THE FINAL DOCUMENTS OR ORDERS FROM THE ISSUING STATES, COURTS, AND/OR AGENCIES MUST BE SUBMITTED ALONG WITH THIS APPLICATION.** Additional information may be requested and/or required before a licensure decision may be made.

For the purposes of these questions, the following phrases or words have the following meanings:

1. **“Ability to practice your profession”** is to be construed to include all of the following:
  - a. The cognitive capacity to make appropriate clinical diagnoses, exercise reasoned medical judgments, to learn, and keep abreast of medical developments;
  - b. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
  - c. The physical capability to perform professional tasks and procedures required of your profession, with or without the use of aids or devices, such as corrective lenses or hearing aids.
2. **“Medical Condition”** includes physiological, mental or psychological conditions including, but not limited to: orthopedic, visual, speech and/or hearing impairments, emotional or mental illness, specific learning disabilities, drug addiction, and alcoholism.



3. "Minor Traffic Offense" generally means moving and non-moving violations punishable by fines only and does not include offenses such as driving under the influence or while intoxicated or reckless driving.

4. "Chemical substances" is to be construed to include alcohol, drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

5. "Currently" does not mean on the day of or even in the weeks or months preceding the completion of this application. Rather it means recently enough so that the use of drugs or alcohol may have an ongoing impact on one's functioning as a licensee or within the past two (2) years.

6. "Illegal use of illicit or controlled substances" means the use of substances obtained illegally (e.g., heroin or cocaine) as well as the use of controlled substances that are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

**QUESTIONS: Please respond to ALL questions. If you answer "YES" to any question, please attach a written explanation.**

- |  | YES   | NO    |
|--|-------|-------|
| 1. Do you currently have any physical or psychological limitations or impairments caused by an existing medical condition which are reduced or ameliorated by ongoing treatment or monitoring, or the field of practice, the setting or the manner in which you have chosen to practice? | _____ | _____ |
| 2. Do you currently use any chemical substances which in any way impair or limit your ability to practice your profession with reasonable skill and safety?  | _____ | _____ |
| If so, please list: _____  |       |       |

*[If you receive such ongoing treatment or participate in such a monitoring program, the Council will make an individual assessment of the nature, the severity and the duration of the risks associated with an ongoing medical conditions so as to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are ineligible for licensure.]*

- |   |       |       |
|---|-------|-------|
| 3. At any time within the past two years, have you engaged in the illegal use of illicit or controlled substances?  | _____ | _____ |
| 4. Are you currently participating in a supervised rehabilitation program or professional assistance program that monitors you in order to assure that you are not engaged in the illegal use of illicit or controlled substances?  | _____ | _____ |
| 5. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism or other diagnosis of a predatory nature?  | _____ | _____ |
| 6. Have you ever held or applied for a license, privilege, registration or certificate to practice as a hearing aid dispenser in any state, country, or province, that has been or was ever denied, reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action? | _____ | _____ |
| 7. Have you ever had staff privileges at any hospital or health care facility that were ever revoked, suspended, curtailed, restricted, limited, otherwise disciplined, or voluntarily surrendered under threat of restriction or disciplinary action?  | _____ | _____ |

		<b>YES</b>	<b>NO</b>
8.	Have you ever applied for or held a state or federal controlled substance certificate that was ever denied, revoked, suspended, restricted, voluntarily surrendered or otherwise disciplined or surrendered under threat of restriction or disciplinary action?	_____	_____
	Have you ever been convicted (including a nolo contendere plea or guilty plea) of a felony or misdemeanor (other than a minor traffic offense) whether or not sentence was imposed or suspended?	_____	_____
10.	Have you ever been rejected or censured by a professional association or society?	_____	_____
11.	In relation to the performance of your professional services in any profession:		
	a. Have you ever had a final judgment rendered against you;	_____	_____
	b. Have you ever entered into any settlement of any legal action; or	_____	_____
	c. Are there any legal actions pending against you or to which you are a party?	_____	_____
12.	Have you ever held a license, registration, privilege or certificate in any profession that has ever been reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action in any jurisdiction?	_____	_____
13.	My name has been placed on the registry of persons who have abused, neglected or misappropriated the property of vulnerable individuals (Tennessee abuse registry or an abuse registry in another state)	_____	_____

**AFFIDAVIT AND RELEASE**

I, \_\_\_\_\_ of \_\_\_\_\_ being duly sworn and identified as the person referred to in this application attest to the truth of each statement made in said application. I further swear that I have read and understand the law and the Rules and Regulations regarding the practice of my profession, which are posted on the Board's Internet site and/or were provided to me by the Board office, and agree to abide by them in the practice as a hearing instrument specialist in the State of Tennessee.

**I HEREBY:**

**SIGNIFY** my willingness to appear to answer such questions as the Board may find necessary, which may include a full Board interview.

**RELEASE** to the Board, its staff, and their representatives, any and all documentation necessary now and in the future to establish my physical and mental capabilities to safely practice as a hearing instrument specialist.

**AUTHORIZE** the Board, its staff, and their representatives to consult with my prior and current associates and others who may have information bearing on my professional competence, character, health status, ethical qualifications, ability to work cooperatively with others, and other qualifications.

**RELEASE** from liability the Board, its staff, and all their representatives and any and all organizations which provide information for their acts performed and statements made in good faith without malice concerning my competence, ethics, character, and/or other qualifications, for certification.

**ACKNOWLEDGE** that I, as an applicant for licensure, have the burden of producing adequate information for a proper evaluation of my professional, ethical, and other qualifications, and for resolving any doubts about such qualifications.

**AUTHORIZE** release, use and disclosure of otherwise HIPAA protected health information to the limited extent necessary for my application to receive full consideration up to and including discussion in a public forum should that become necessary.

**THIS CERTIFIES THAT THE INFORMATION SUBMITTED BY ME IN THIS APPLICATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.**

\_\_\_\_\_  
**SIGNATURE**

\_\_\_\_\_  
**DATE**

**PHYSICIAN'S CERTIFICATION**

This is to certify that \_\_\_\_\_ is free of any contagious or infectious diseases.  
(Applicant Name)

\_\_\_\_\_  
Physicians' Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician's Name - Printed

\_\_\_\_\_  
Office Phone

\_\_\_\_\_  
Office Address

\_\_\_\_\_  
City, State, Zip



TENNESSEE DEPARTMENT OF HEALTH  
OFFICE OF HEALTH LICENSURE AND REGULATION  
665 MAINSTREAM DR  
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OUTLINE OF PROGRAM SUPERVISION

This is to inform the Council for Licensing Hearing Instrument Specialists that \_\_\_\_\_  
APPRENTICE'S NAME

will be working under my supervision at \_\_\_\_\_  
COMPANY NAME

\_\_\_\_\_  
ADDRESS CITY STATE

during the hours of \_\_\_\_\_. If any field appointments are made,  
\_\_\_\_\_ will be working with him/her.

Business Phone Number (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

The following subjects will be covered:

<u>Topics</u>	<u>Hours</u>
_____	_____
_____	_____
_____	_____
_____	_____

In addition to case histories and audiometric data used in my office, the following training materials will be used:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If I can be of further assistance, you may contact me by calling \_\_\_\_\_.

\_\_\_\_\_  
Supervisor's Signature

\_\_\_\_\_  
Date

HIS License Number \_\_\_\_\_