

Oregon Health Licensing Agency



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Fax: (503) 370-9004
Web Site: <http://www.oregon.gov/OHLA>
E-Mail: ohla.info@state.or.us

Application Fee 1521 \$50
Application Fee is non-refundable.
Submit fees and application together.

Amt REC'D _____
CK / MO/ V/ MC/ C: _____
INT _____

Advisory Council on Hearing Aids

\$50

HEARING AID SPECIALIST TRAINEE REGISTRATION AGREEMENT

PLEASE PRINT:

Male Female Date of Birth _____ SSN _____

TRAINEE

Name			
Mailing Address			
City	State	Zip	Home Telephone ()

TRAINER

Name		License Number	
Business Facility Name			
Business Address			
City	State	Zip	Home Telephone ()
Trainee's Starting Date		Projected Ending Date	

TRAINEE - READ AND SIGN

I agree to fulfill the requirements of my training by:

1. Performing the activities required by rule and as described on the Certification of Training form;
2. Working only under the direct supervision of my trainer, one on one during the completion of my training;
3. Developing theory and practical skills by accepting the guidance and assistance provided to me by my trainer;
4. Notifying the Health Licensing Agency in writing within 5 working days of any problems encountered during my training, or if my training is interrupted or terminated for any reason; and
5. Responding to requests for information from the Health Licensing Agency regarding the process of my training.

Trainee Signature

Date

TRAINER - READ AND SIGN

Declaration of responsibility to be completed per Oregon Administrative Rules 331-610-0000, 0010 and 0020.

I agree to fulfill the requirements of a trainer by:

1. Submitting a completed Certification of Training form at the conclusion of training;
2. Assigning activities required by rule and as described on the Certification of Training form to the trainee;
3. Providing direct supervision, guidance, and assistance to the trainee, increasing the complexity of assignments regularly to allow the trainee to develop theory and practical skills necessary for practice;
4. Notifying the Health Licensing Agency in writing within 5 working days of any problems encountered during this training agreement, or if the training is interrupted or terminated for any reason, and including submission of a completed Certification of Training form on trainee; and,
5. Responding to requests for information from the Health Licensing Agency regarding the progress of the training.
6. Not supervising more than four (4) trainee's at any one time.

Trainer Signature

Date

DECLARATION OF RESPONSIBILITY TO BE COMPLETED BY THE SUPERVISOR AND APPLICANT WHEN APPLICATION FOR A TEMPORARY LICENSE IS MADE:

I, _____, a licensed hearing aid specialist in the State of Oregon, understand and will perform all of the activities and duties for which I am responsible, per Oregon Administrative Rules 333-025-0006,0007, and 0008 regarding the applicant named below. I will notify the Health Licensing Agency within 30 days if the applicant ceases for any reason to be under my supervision.

Supervisor Signature

License #

Date

Applicant's Signature

Date