State of New Hampshire

OFFICE OF PROFESSIONAL LICENSURE AND CERTIFICATION
DIVISION OF LICENSING AND BOARD ADMINISTRATION
Allied Health
7 Eagle Square, Concord, NH 03301-4980
Phone: 603-271-2152

SUPERVISED PRACTICE PLAN
FOR HEARING CARE PROVIDERS

TO BE COMPLETED BY APPLICANT

General Information:

Name:____
(Last) (First) (Middle Initial)

Address:____

____

Telephone Business (_____) ______________________ Home (_____) _______________________

Date of Birth:____________________ E-mail Address:_________________________________

Training Program Responsibilities: The supervising trainer shall, prior to its implementation, submit to the Board a plan that includes training to develop and demonstrate competency in:

- Hearing Testing and Interpretation
- Otoscopic Ear Examination
- Earmold Impression Procedures
- Hearing Aid Selection and Fitting Protocol
- Hearing Aid Troubleshooting and Servicing

Employment Information:

Employer____
(Company Name) (Division or Department)

Address ____
(Street)

____
(City) (State) (Zip Code)

TO BE COMPLETED BY SUPERVISOR

Beginning Date of Employment ________________________

Date Supervised Training Program to Start ________________

Date Supervised Program to End ________________________

Average Number of Hours Per Week _____________________

Supervisor's Name: ____
(Last) (First) (Middle Initial)

Address:____
(Street)

____
(City) (State) (Zip Code)

Telephone Business: (_____) __________________ Home: (____) ____________________

Registration# __________________

This Plan Must Be Completed, Signed, And Returned To The Board Office Within Thirty (30) Calendar Days Of The Start Of Your Supervised Training Program.