SOUTH CAROLINA DEPARTMENT OF PUBLIC HEALTH

Application for Examination for Hearing Aid Specialist Licensure Eligibility

Today's Date: _____ Which test are you applying for? ☐ Written ☐ Practical

PERSONAL INFORMATION

Name: _____ Date of Birth: _____
First Middle Initial Last

Residence Address: _____
Street City State Zip

Mailing Address: _____
(If Different) Street City State Zip

Phone Number: _____ Email Address: _____
(+ Area Code)

PRIMARY BUSINESS INFORMATION

Business Name: _____

Business Address: _____
Street City State Zip

Mailing Address: _____
(If Different) Street City State Zip

Phone Number: _____
(+ Area Code)

Do you have a South Carolina Temporary Permit? ☐ Yes ☐ No If yes, Permit No.: _____

OTHER INFORMATION

Have you ever been convicted of any criminal offense other than minor traffic violations?

☐ Yes ☐ No If yes, attach a separate statement providing details to include date of conviction, type of offense, and name and location of court.

Have you ever had a license to dispense, fit, or sell hearing aid denied, suspended, or revoked in this or any other state?

☐ Yes ☐ No If yes, attach a separate statement providing details, dates, and places.

I do hereby swear or affirm that all statements made and information contained herein are true and correct to the best of my knowledge and belief. Furthermore, I voluntarily consent to an investigation of the aforementioned information for the purpose of verifying my qualifications for a license to fit and sell hearing aids in the State of South Carolina.

_____
Signature Date

RETURN APPLICATION TO: SCDPH, Division of Health Licensing, P.O. Box 2046, West Columbia, SC 29171.
Personal information provided on this form is subject to public scrutiny or release.

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Instructions for Completing 0220-ENG-DPH

PURPOSE: This is an external form used by customers to apply for a health license or service regulated by Healthcare Quality.

AUDIENCE: DPH Customers.

INSTRUCTIONS: Customers will complete this application when applying for a healthcare facility or service regulated by Healthcare Quality. This application is to be used in conjunction with the facility's regulation.

OFFICE MECHANICS & FILING: The completed form will be stored on the Bureau of Operations Support's SharePoint Site / OneDrive. This form is maintained by retention schedule 16327 — Masterfiles. Once the 10-year retention period has been met and quality review has been completed, an ARM-11 destruction request should be submitted and approved prior to disposal of the original form.