



**Student Registration Agreement and Declaration of Responsibility**

Student and Supervisor to complete and submit with Student Registration Application

**1. Student: READ AND SIGN**

**I agree to fulfill the requirements of my training by:**

1. Performing the activities required by rule and by the Washington Hearing Society - Hearing Aid Specialist Training Program.
2. Wearing a name badge identifying myself as a student.
3. Completing training in theory and practical skills as required by the International Hearing Society Training Course for Hearing Aid Specialists. I will complete 520 hours of practical training. A minimum of 260 hours will be under direct supervision the remainder may be direct or indirect.
4. Working under the supervision of my supervisor in compliance with WAC 246-828-075.
5. Notifying the WHS Program Coordinator and the Department of Health Board of Hearing & Speech (DOH) within five (5) business days of any problems relating to my training or if my training must be interrupted or terminated for any reason.
6. Respond to any/all requests from the WHS Program Coordinator or the D.O.H. regarding the progress of my training.

**STUDENT NAME:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Print Clearly

**STUDENT ADDRESS:** \_\_\_\_\_

**STUDENT PHONE:** \_\_\_\_\_ **EMAIL:** \_\_\_\_\_

**STUDENT SIGNATURE:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**SUPERVISOR: READ AND SIGN:**

**QUALIFICATIONS:**

**Pursuant to WAC 246-828-075, I attest that:**

- I am currently licensed AND in good standing under chapter 18.35 RCW. My license number is: \_\_\_\_\_
- I have practiced for at least thirty-six (36) of the last forty-eight (48) months

**Supervisor Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**I agree to fulfill the requirements of a supervisor by:**

- Providing direct and indirect supervision as required under WAC 246-828-075
- Provide supervision to no more than three (3) students at a time.
- Cosigning all purchase agreements for the sale of hearing aids made by the above named student
- Notifying the WHS Program Coordinator AND the DOH within (5) business days if the training of the above named student is interrupted or terminated for any reason.
- Respond to any/all requests for information from the WHS Program Coordinator or the Department of Health regarding the progress of the student's training or of my supervision of the student.
- Submitting a completed Certification of Training form to the WHS Program Coordinator at the completion of the student's training

I, \_\_\_\_\_ a licensed Hearing Aid Specialist or Audiologist (circle one) in the state of Washington, agree to supervise the above named student, and to perform all of the activities and duties required under the Washington Administrative Code for the supervision of students. By signing below, I attest that all of the information provided on this form is true and accurate.

**SUPERVISOR NAME:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Print Clearly

**SUPERVISOR ADDRESS:** \_\_\_\_\_

**SUPERVISOR PHONE:** \_\_\_\_\_ **EMAIL:** \_\_\_\_\_

**SUPERVISOR SIGNATURE:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Return a copy of this document to the WHS Program Coordinator and keep one for your records**