

Washington Hearing Society PO Box 821090

Vancouver, WA 98685

Attn: Sandy Hubbard

sandyh@washingtonhearing.org

HEARING AID SPECIALIST TRAINING PROGRAM APPLICATION							
1. APPLICANT INFORMATION							
APPLICANT I	NAME: LAST FIRST				MIDDLE INITIAL		
RESIDENTIAI	L/PHYSIC	CAL ADDRESS (REQ	UIRED)				
CITY					STATE	ZIP	
MAILING AD	DRESS (I	F DIFFERENT FROM	A RESIDENTIAL ADDRESS			l	
CITY					STATE	ZIP	
PHONE				Email:	:		
Gender: ☐ Male ☐ Female Birthdate So				Social Secur	Social Security Number: (Required)		
Have you ever been known under any other name? \square No \square YES - if Yes, list full name(s):							
Are you a U.S. Veteran? □ YES □ No							
			an American 🗆 Hispanic	/Latino 🗆 Ame	erican Indian/ <i>I</i>	Alaska Native 🗆	
Disability Yes □ No □							
Last School Attended State Degree Earned Year						Year	
Do you hold or have you previously held licensure, certification or registration with the Department of Health							
State:	License/Cert./Reg. #				Expiration:		
State:	License/Cert./Reg. #				Expiration:		
State:	License/Cert./Reg. #				Expiration:		
2. Method of Payment for Application Fee = \$100.00							
Please check one: ☐ Check ☐ Credit Card (See Below) ☐ Money Order							
Type of Credit Card: Visa Master Card Discover (Cardholder name must match applicant or be							
present at time application is submitted) Do Not Fax or Email Credit Card Information							
Name on Ca	rd:						
Card Numbe	er:		Ex	p: Se	curity Code:		
Cardholder S					_		
(Do not write in this section - Offical use only)							
Registration #:IntialsVerified ID ID Type:							
Approval Code/CK#							