



Washington Hearing Society
11850 NE 99th St, Suite 1350
Vancouver, WA 98682
360-433-9618

HEARING AID SPECIALIST TRAINING PROGRAM APPLICATION

1. APPLICANT INFORMATION

APPLICANT NAME: LAST FIRST MIDDLE INITIAL

RESIDENTIAL/PHYSICAL ADDRESS (REQUIRED)

CITY	STATE	ZIP
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MAILING ADDRESS (IF DIFFERENT FROM RESIDENTIAL ADDRESS)

CITY	STATE	ZIP
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PHONE Home Cell

Business Telephone

Email:

Gender: Male Female

Birthdate

Social Security Number: (Required)

Have you ever been known under any other name? No YES - if Yes, list full name(s):

Race: White/Caucasian Black/African American Hispanic/Latino American Indian/Alaska Native Asian Hawaiian Native or other Pacific Islander Multi-Racial Other

Disability Yes No

Last School Attended _____ State _____ Degree Earned _____ Year _____

Do you hold or have you previously held licensure, certification or registration with the Department of Health or any other state licensing department? NO YES - If Yes, please list information below.

State:	License/Cert./Reg. #	Expiration:
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State:	License/Cert./Reg. #	Expiration:
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State:	License/Cert./Reg. #	Expiration:
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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 Card: _____

Card Number: _____ Exp: _____ Security Code: _____

Cardholder Signature: _____

(Do not write in this section - Official use only)

Registration #: _____ Intials _____ Verified ID ID Type: _____

Approval Code/CK#