MISSISSIPPI STATE DEPARTMENT OF HEALTH

HEARING AID SPECIALIST

SUPERVISION AGREEMENT

Temporary License Applicant

Name: ____
Last *First* *Middle/Maiden*

Employer: ____

Business Address: ____

______________________________________ Phone: ____________________
City *State* *Zip Code*

Supervising Hearing Aid Specialist

MS License Number: ______________________

Name: ____
Last *First* *Middle/Maiden*

Email Address: ____

Business Address: ____

______________________________________ Phone: ______________________
City *State* *Zip Code*

Beginning Date of Supervision: _______/_______/________

Supervising Credentials

Check boxes where applicable and attach a copy of current credential(s):

1. Currently hold the National Board for Certification in Hearing Instrument Sciences (NBC-HIS) Certificate
2. Currently hold the ASHA Certification of Clinical Competence (CCC-A)
3. Have held licensure in the testing of hearing, fitting of hearing aids, and dispensing of hearing aids for at least three (3) years

Any changes in this agreement must be reported to the Mississippi State Department of Health, Bureau of Professional Licensure within ten (10) working days.

I, the undersigned, do solemnly swear or affirm that I am the above licensee. I have read the above agreement and all statements contained therein or accompanying this agreement are true to the best of my knowledge and belief. I agree to adhere to the rules and regulations governing the supervision of temporary licensees and will provide the applicant with the training listed in Rule 6.10.3 of the regulations

______________________________ ______________________________

Temporary Licensee Applicant Signature Supervising Licensee Signature

Complete form and mail to:
Mississippi State Department of Health
Professional Licensure: Hearing Aid Dealers
Post Office Box 1700
Jackson, Mississippi 39215-1700