

Colorado Division of Registrations  
**Office of Licensing—Hearing Aid Provider**  
1560 Broadway, Suite 1350  
Denver, CO 80202  
Phone: (303) 894-7800  
FAX: (303) 894-7693  
[www.dora.state.co.us/registrations](http://www.dora.state.co.us/registrations)

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## **REINSTATEMENT APPLICATION—HEARING AID PROVIDER**

### **APPLICANT INSTRUCTIONS**

**Mandatory Practice Act.** Colorado has a mandatory practice act, which means that you may not practice as a Hearing Aid Provider in this state without a Colorado license. Submission of this application does not guarantee licensure. Therefore, do not make life or career decisions based on the probability that you may receive a license. Plan ahead for the time it will take for us to receive all required documents and complete our evaluation.

**Basic Requirements.** Requirements for licensure are outlined in the Colorado Revised Statutes, specifically 12-5.5-101, and the Rules and Regulations. Both are available online at [www.dora.state.co.us/audiologists](http://www.dora.state.co.us/audiologists).

The Medical Practice Act and complete rules and policies are available online at [www.dora.state.co.us/medical](http://www.dora.state.co.us/medical). In compliance with the Michael Skolnik Medical Transparency Act of 2010, licensees are required to complete an online Healthcare Professions Profile on our website at [www.dora.state.co.us/hppp](http://www.dora.state.co.us/hppp).

**About the Application.** This application is to be completed by you and returned to the Office of Licensing. All questions on the application are mandatory, and all supporting documents must be submitted with the application. You may copy as many forms as needed; however, each form submitted must be completed in original ink or typed. Keep a copy of the completed application for your records.

**Application Expiration.** Your application will be kept on file for one (1) year from date of receipt in the Division. Your file and all supporting documentation will be purged if you do not submit required documents and complete your application process in one year. You will need to resubmit a new application packet and fee after that time.

**Social Security Number is Required.** Effective January 1, 2009, a Social Security Number is required for all licensees. The Division will consider an application to be incomplete when the applicant fails to submit his/her Social Security Number. Exceptions are made for foreign nationals not physically present in the United States and for non-immigrants in the United States on student visas who do not have a Social Security Number. These applicants must submit a signed Social Security Number Affidavit in lieu of a Social Security Number. You may call (303) 894-7800 to request that an affidavit be mailed to you.

**Disclosure of Addresses.** Consistent with Colorado law, all addresses and phone numbers on record with the Division are public record and must be provided to the public when requested. It is your responsibility to keep your address and contact information up-to-date in our database. All letters, renewal notices, and licenses are mailed to the last known address of record. **If your address is not current, it is possible you will not receive important documents.** You can change your address online by using Registrations Online Services at [www.doradls.state.co.us](http://www.doradls.state.co.us).

**License Expiration Grace Period for Applicants.** All new applicants who are issued a license within 120 days of the upcoming renewal expiration date will be issued a license with the subsequent expiration date. For example, licenses issued between December 1, 2011 and March 31, 2012 will reflect a license expiration date of March 31, 2014. Licenses issued prior to December 1, 2011 will reflect an expiration date of March 31, 2012 and must renew in the upcoming renewal period.

- All Colorado Hearing Aid Provider licenses expire on March 31 of even-numbered years and must be renewed to continue practicing.

## APPLICANT CHECKLIST

### To reinstate your expired Colorado Hearing Aid Provider license:

- Complete the attached application.** Return the completed application and all supporting documentation to the Office of Licensing.
- Enclose the non-refundable application processing fee.** See page 1 of the application form for current fees. Fees may be paid by a check or money order drawn in U.S. dollars on a U.S. bank and **made payable to State of Colorado**. All fees are non-refundable and subject to change every July 1.
- Complete and return the attached Affidavit of Eligibility form.** Pursuant to C.R.S. 24-34-107, all applicants for licensure are required to complete and sign an Affidavit of Eligibility, and may also be required to provide a copy of a secure and verifiable document.
- Provide documentation of any name change.** If your name has changed since you obtained a previously-issued license, or if your name is different on any of your supporting documentation, you must provide a copy of the legal document verifying the name change (i.e., marriage license, divorce decree, or court order).
- Complete a Healthcare Professions Profile.** In compliance with the Michael Skolnik Medical Transparency Act of 2010, you are required to complete an online profile on our website at [www.dora.state.co.us/hppp](http://www.dora.state.co.us/hppp). You cannot start your profile until the Division of Registrations receives your application and enters it into our database. Allow 10 days from the date your application was mailed before accessing the website. If you have questions or technical issues regarding your online profile, contact the Healthcare Professions Profiling Program at [hppp@dora.state.co.us](mailto:hppp@dora.state.co.us) or (303) 894-5942.

### Return your completed application packet and all supporting documentation to:

Division of Registrations  
**Office of Licensing—Hearing Aid Provider**  
1560 Broadway, Suite 1350  
Denver, CO 80202



## IMPORTANT NOTICE

**TO:** All Applicants

**FROM:** Rosemary McCool, Director, Division of Registrations

**SUBJECT:** Licensure and Criminal History

Thank you for your interest in becoming a licensed\* professional within the Division of Registrations. Before you submit your application, please be aware of a few facts regarding criminal conduct, convictions, and disciplinary actions in other states.

The mission of the Division of Registrations is “public protection through effective licensure and enforcement.” One way the Division safeguards consumers is by issuing licenses to fully qualified, competent, and ethical applicants.

During the licensing process – and depending on the specific application – the Division will ask whether you have ever been disciplined in any state, arrested, charged, convicted, or pled guilty to a crime. An arrest, subsequent criminal conviction, or disciplinary action is not an automatic disqualification from licensure. Instead, the appropriate board or program will look at the facts surrounding the criminal conduct and disciplinary action to determine whether you are fit for licensure. You should know that licensure is a privilege, not a right. One thing you must do to obtain the privilege is to be completely honest on your application.

Be sure to list all relevant complaints, disciplinary actions, arrests, charges, or convictions in response to the licensure questions. Failure to fully disclose could constitute grounds alone for denial of your application or revocation of your license. More important, avoid some of the common excuses we have heard from people who failed to disclose, such as:

- My attorney told me I didn’t have to disclose the criminal conduct or disciplinary actions.
- I didn’t think the prior conduct had anything to do with the profession.
- I didn’t think the disciplinary action, arrest, charges, or conviction was still on my record.
- I didn’t think it was subject to disclosure because I received a deferred sentence/judgment.

Remember, there is no excuse not to disclose disciplinary actions and criminal conduct. Even after licensure, you are still required to notify your professional licensing board or program about subsequent convictions and disciplinary actions in other states.

The Division conducts audits of its licensing database against several criminal and national disciplinary databases. This allows the Division to verify the truthfulness of your application and track subsequent criminal and disciplinary conduct after initial licensure. Keep in mind, you will not necessarily be revoked or denied a license if you have been disciplined, arrested, charged or convicted, but you will most likely be denied or revoked if you fail to disclose it.

*\*The word "license" is used as a general term. While most of the professions and occupations are licensed, others may be registered, certified, or listed. For precise terminology and requirements related to a profession or occupation, please consult the [website](#) of the appropriate board or program.*



**Colorado Department of Regulatory Agencies**  
 Division of Registrations  
 1560 Broadway, Suite 1350  
 Denver, CO 80202

**Licensee/Applicant Full Legal Name**

Last	First	Middle	Suffix

**Colorado Professional or Occupational License/Certification/Registration Number:** \_\_\_\_\_  
 (if already licensed)

**Professional or Occupational License/Certification/Registration type applying for:** \_\_\_\_\_

**AFFIDAVIT OF ELIGIBILITY**

Pursuant to H.B. 06S-1009, C.R.S. 24-34-107, ALL applicants for original licensure\* or licensees renewing or reinstating a current Colorado license after January 1, 2007 are required to complete and sign this Affidavit of Eligibility.

*\*The word "licensure" is used as a general term. While most of the professions and occupations are licensed, others may be certified, registered, or listed. For precise terminology and requirements related to a profession or occupation, please consult the website of the appropriate board or program.*

**Section A: LAWFUL PRESENCE in the United States**

1.  I am a U.S. citizen. Check one of the acceptable secure and verifiable documents in Section B that applies and fully complete the information requested. Complete documentation must be provided upon request.
2.  I am not a U.S. citizen, but I am lawfully present in the U.S. and authorized by the Department of Homeland Security to be employed in the U.S. Check one of the acceptable secure and verifiable documents in Section B that applies and fully complete the information requested. Complete documentation must be provided upon request.
3.  I am not physically present in the U.S. under 8 U.S.C. sec. 1621 (c)(2)(c) or employed in the U.S. pursuant to 8 U.S.C. sec. 1621 (c)(2)(a). Check one option, a or b below, then skip to Section C. (Do not complete Section B.)
  - a.  I am a U.S. citizen, not physically present or employed in the United States.
  - b.  I am a Foreign National, not physically present or employed in the United States.

**Section B: SECURE AND VERIFIABLE DOCUMENTS**  
 Select ONE document in this section if you checked 1 or 2 in Section A.

Government Issued Identification	Name of state agency or federal agency that issued the document	Full name as shown on driver's license or state/federal issued ID	License/ID Number	Expiration Date (mm/dd/yyyy)
<input type="checkbox"/> Driver's license or permit				
<input type="checkbox"/> Government issued ID card				
<input type="checkbox"/> Valid U.S. military ID/common access card				
<input type="checkbox"/> Colorado Department of Corrections inmate ID				
<input type="checkbox"/> Tribal ID card				
<input type="checkbox"/> U.S. passport				
<input type="checkbox"/> Certificate of Naturalization				

**Section B: SECURE AND VERIFIABLE DOCUMENTS (continued)**

<b>Government Issued Identification</b>	<b>Name of state agency or federal agency that issued the document</b>	<b>Full name as shown on driver's license or state/federal issued ID</b>	<b>License/ID Number</b>	<b>Expiration Date (mm/dd/yyyy)</b>	
<input type="checkbox"/> Certificate of (U.S.) Citizenship					
<input type="checkbox"/> Valid Temporary Resident card					
<input type="checkbox"/> Valid I-94 issued by Canadian government					
<input type="checkbox"/> Valid I-94 with refugee/asylum stamp					
<input type="checkbox"/> Valid I-766 (Employment Authorization Card)			<b>Issuing federal agency:</b>		
<b>Name on card</b>	<b>Alien Number (A#)</b>	<b>Card Number</b>	<b>Valid from (mm/dd/yyyy)</b>	<b>Expires (mm/dd/yyyy)</b>	
<input type="checkbox"/> Valid I-551 (Resident Alien or Permanent Resident Card)			<b>Issuing federal agency:</b>		
<b>Name on card</b>	<b>Alien Number (A#)</b>	<b>Country of birth</b>	<b>Card expires (mm/dd/yyyy)</b>	<b>Resident since (mm/dd/yyyy)</b>	
<input type="checkbox"/> Valid foreign passport with an unexpired visa with proper classification for work authorization, and an unexpired I-94					
<b>Issuing foreign country</b>	<b>Passport Number</b>	<b>Visa Number</b>	<b>Visa Class (ex.: J-1, P-1, H-1B, etc.)</b>	<b>Date of entry (mm/dd/yyyy)</b>	<b>Until date (mm/dd/yyyy)</b>
<input type="checkbox"/> Valid foreign passport bearing an unexpired "Processed for I-551" stamp or with an attached unexpired "Temporary I-551" visa					
<b>Issuing foreign country:</b>			<b>Passport Number:</b>		

**Section C: ATTESTATION**

- I understand that this sworn statement is required by law because I have applied for or hold a professional or commercial license regulated by 8 U.S.C. sec. 1621. I understand that state law requires me to provide proof that I am lawfully present in the United States when asked as well as submission of a secure and verifiable document. I may also be required to provide proof of lawful presence.
- I understand that in accordance with sections 18-8-503 and 18-8-501(2)(a)(I), C.R.S., false statements made herein are punishable by law. I state under penalty of perjury in the second degree, as defined in 18-8-503, C.R.S. that the above statements are true and correct.
- I am the person identified above and the information contained herein is true and correct to the best of my knowledge. I understand that under Colorado law, providing false information is grounds for denial, suspension or revocation of a license, certificate, registration or permit.
- I understand that the above information must be disclosed to the Department of Regulatory Agencies upon request and is subject to verification.

\_\_\_\_\_  
Print Full Legal Name

\_\_\_\_\_  
Signature (Full Name)

\_\_\_\_\_  
Date

**The content of this application must not be changed.** If the content is changed, the applicant may be referred to the Colorado State Attorney General's Office for violation of Colorado law.

**Fees may be paid by check or money order drawn in U.S. dollars on a U.S. bank and made payable to *State of Colorado*.**

Colorado Hearing Aid Provider License Number: \_\_\_\_\_ Date License Expired: \_\_\_\_\_

**PART 1—APPLICANT INFORMATION**

<b>Name:</b> Last:		First:	Middle:	Suffix:
<b>Previous Name(s):</b>				
<b>Social Security Number: *</b>		<b>Date of Birth</b> (mm/dd/yyyy):	<b>Gender:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	
<b>Place of Birth</b> (city and state, or foreign country):				
<b>Mailing Address:</b> <i>This is a</i> <input type="checkbox"/> Home <input type="checkbox"/> Business		PO Box, Street:		
		City, State, Zip:		
<b>Daytime Telephone Number:</b> (     )			<b>E-mail Address:</b> <i>Preferred method for communication:</i> <input type="checkbox"/> Mail <input type="checkbox"/> E-mail	

**PART 2—LICENSE INFORMATION**

Since the date your Colorado Hearing Aid Provider license expired, have you been practicing as an Hearing Aid Provider:  
 in the state of Colorado?  YES  NO

Since the date your Colorado Hearing Aid Provider license expired, have you been practicing as a Hearing Aid Provider:  
 in another jurisdiction?  YES  NO

List each jurisdiction, other than Colorado, in which you are or have been licensed as a Hearing Aid Provider. If needed, attach an additional sheet using the same format. If not applicable, enter N/A.

State/Country	License Number	Year license issued	Disciplinary action against license?	Is this license current/active?
			<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
			<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
			<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

\*Social Security Number Disclosure: Section 24-34-107(1) of the Colorado Revised Statutes requires that every application by an individual for a license issued pursuant to the authority set forth in Title 12, C.R.S., by the Department of Regulatory Agencies, shall require the applicant's Social Security Number. Disclosure of your Social Security Number is mandatory for purposes of establishing, modifying, or enforcing child support under Section 14-14-113 and Section 26-13-126, C.R.S.; locating an individual who is under an obligation to pay child support as required by Section 26-13-107(3)(a)(I)(A), C.R.S.; and reporting to the Health Integrity and Protection Data Bank as required by 45 CFR Section 61.1 *et seq.* Failure to provide your Social Security Number for these mandatory purposes will result in the denial of your licensure application. Disclosure of your Social Security Number is voluntary for disclosure to other state regulatory agencies, testing and examination vendors, law enforcement agencies, and other private federations and associations involved in professional regulation for identification purposes only. Your Social Security Number will not be released for any other purpose unless provided for by law.

**PART 3—COMPETENCY TO PRACTICE**

If your license has been expired **more than two (2) years, but less than five (5) years**, from the date your reinstatement application is received in the Division, demonstrate competency to practice by:

- Verification of licensure in good standing from another state: Provide a printout of your active Hearing Aid Provider license from the state's webpage verifying your license; **and** proof of active practice in that state for two (2) years of the previous five (5) years from the application receipt date: Use the attached Verification of Hearing Aid Provider Practice form;

**OR**

- Record of completion of 30 hours of continuing education courses related to the practice of a Hearing Aid Provider during the two (2) years immediately preceding the application receipt date: Use the attached Hearing Aid Provider Continuing Education Record;

**OR**

- Proof of retaking and achieving a passing score on the NBC-HIS examination within two (2) years immediately preceding application receipt date: Submit either a copy of your certificate, notification letter, or wallet card;

**OR**

- Proof of having maintained active Board certification with NBC-HIS: Submit either a copy of your certificate or wallet card showing you have maintained current status;

**OR**

- Proof of supervised practice for a period of no less than six (6) months subject to the terms established by the Director: Use the attached Verification of Hearing Aid Provider Practice form;

**OR**

- Any other means approved by the Director.

If your license has been expired **more than five (5) years** from the receipt date, demonstrate competency to practice by:

- Verification of licensure in good standing from another state: Provide a printout of your active Hearing Aid Provider license from the state's webpage verifying your license; **and** proof of active practice in that state for two (2) years of the previous five (5) years from the application receipt date: Use the attached Verification of Hearing Aid Provider Practice form;

**OR**

- Proof of retaking and achieving a passing score on the NBC-HIS examination within two (2) years immediately preceding application receipt date: Submit either a copy of your certificate, notification letter, or wallet card;

**OR**

- Proof of having maintained active Board certification with NBC-HIS: Submit either a copy of your certificate or wallet card showing you have maintained current status;

**OR**

- Proof of supervised practice for a period of no less than six (6) months subject to the terms established by the Director: Use the attached Verification of Hearing Aid Provider Practice form;

**OR**

- Any other means approved by the Director.

**PART 4—SCREENING QUESTIONS**

**You must provide the following for each “YES” response to the screening questions below:**

- An explanation, signed and dated by you, of your behavior or practice that led to the occurrence, including:
  - Date(s) of event/offense
  - Description of event/offense
  - Location/court
  - Current status/outcome

**You may be required to provide the following:**

- Copies of legal documents relating to the event/offense.
- Copies of legal documents indicating your compliance with any requirements imposed upon you.

- |  |  |
|--|--|
| 1. Are there any pending complaints against you in any other jurisdictions?  | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 2. Have you ever had any disciplinary action taken against you by another jurisdiction?  | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 3. Have you ever been convicted of or accepted a plea of guilty or <i>nolo contendere</i> or received a deferred sentence in any court to a crime involving fraud, deception, false pretense, theft, misrepresentation, false advertising, or dishonest dealing? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 4. Have you ever been convicted of or accepted a plea of guilty or <i>nolo contendere</i> or received a deferred sentence in any court to a felony?  | <input type="checkbox"/> YES <input type="checkbox"/> NO |

**ATTESTATION**

**I state under penalty of perjury in the second degree, as defined in C.R.S. 18-8-503, that the information contained in this application is true and correct to the best of my knowledge. In accordance with C.R.S. 18-8-501(2)(a)(I), false statements made herein are punishable by law and may constitute violation of the practice act.**

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date

## VERIFICATION OF HEARING AID PROVIDER PRACTICE

### APPLICANT

<b>Applicant Name:</b> Last:	First:	Middle:	Suffix:
<b>Applicant Mailing Address:</b> PO Box, Street: <i>This is a</i> <input type="checkbox"/> <i>Home</i> <input type="checkbox"/> <i>Business</i> City, State, Zip:			

### EMPLOYER

This is to certify that the above-named applicant was actively practicing as a Hearing Aid Provider from _____ to _____ for _____ hours per week. (mm/dd/yyyy) (mm/dd/yyyy)	
<b>Employer Signature:</b>	<b>Date:</b>
<b>Employer Name:</b> (print)	<b>Employer Title/Position:</b>
<b>Employer Address:</b> Street and Number: City, State, Zip:	
<b>Employer Telephone:</b> (       )	

**Employer:** Return this completed form to the applicant to be submitted with the application.

