

HEARING AID PROVIDER TRAINEE AND ASSOCIATE SUPERVISOR FORM

**Office of Licensing—Audiology and Hearing Aid Provider
1560 Broadway, Suite 1350, Denver, CO 80202; (303) 894-7800 / FAX (303) 894-7693**

This form is to be completed and forwarded to the Office of Licensing—Audiology and Hearing Aid Provider upon the formation of a supervisory relationship between a licensed audiologist or hearing aid provider and a hearing aid provider trainee or associate in conformance with C.R.S. 12-5.5-202.5(2), Audiology and Hearing Aid Provider Practice Act.

APPLICANT CANNOT PRACTICE OR ACCRUE HOURS PRIOR TO BEING ISSUED A LICENSE NUMBER.

CHECK ONE:

- New registration of a supervisor.
- Change of supervisor, replacing _____.
- Additional supervisor (check if you are working for more than one audiologist or hearing aid provider).

SECTION 1—To be completed by Hearing Aid Provider Trainee or Associate

Trainee or Associate Name: Last:	First:	Middle:	Suffix:
Colorado License Number:			
Practice Address: PO Box, Street: City, State, Zip:			

By my signature, I certify that I have reviewed C.R.S. 12-5.5-202.5(2), Audiology and Hearing Aid Provider Practice Act, and the Rules and Regulations regarding license of and practice by hearing aid provider trainees and associates. I understand that I must comply with all statutes and rules of the Office of Audiology and Hearing Aid Provider Licensure when practicing as a hearing aid provider trainee or associate in Colorado.

I understand that this supervisor/trainee or associate relationship remains in effect until rescinded in writing to the Office by either party. If rescinded, I further understand I may not practice as a hearing aid provider trainee or associate until a new supervisor has been properly registered with the Office of Audiology and Hearing Aid Provider Licensure.

Signature of Hearing Aid Provider Trainee or Associate

Date

SECTION 2—To be completed by the Supervisor

Supervising Audiologist or Hearing Aid Provider Name: Last:	First:	Middle:	Suffix:
Colorado License Number:		<input type="checkbox"/> Audiologist <input type="checkbox"/> Hearing Aid Provider	
Practice Address: PO Box, Street: City, State, Zip:			

By my signature, I certify that I have reviewed C.R.S. 12-5.5-202.5(2), Audiology and Hearing Aid Provider Practice Act, and the Rules and Regulations regarding license of and practice by hearing aid provider trainees and associates. I understand that I must comply with all statutes and rules of the Office of Audiology and Hearing Aid Provider Licensure when practicing as an audiologist or hearing aid provider and serving as an audiologist or hearing aid provider supervisor in Colorado.

I understand that this supervisor/trainee or associate relationship remains in effect until rescinded in writing to the Office by either party.

Signature of Audiologist or Hearing Aid Provider

Date