DEPARTMENT OF HEALTH

SUPERVISOR FORM – TEMPORARY AUDIOLOGIST (AUD) / DISPENSES HEARING INSTRUMENTS

APPLICANT INFORMATION

Last Name | First Name | Middle

Email Address

EMPLOYMENT INFORMATION

Employee/Facility Name

Street Address | City | State | ZIP

To be completed by applicant's supervisor only.

Please print and sign clearly in blue ink.

Last Name | First Name | Middle

Supervisor's MN Audiology License # | Employment Business Name

Street Address | City | State | ZIP

Telephone Number | Employer Telephone Number

Employment Email Address

Date Supervisor Started Employment (mm/dd/yyyy) | Hearing Instrument Dispenser (HID) Certification # (if Certified)

SUPERVISOR AFFIRMATION. *I certify that I am a licensed audiologist in the state of Minnesota and will be the supervisor of the above-named applicant who has applied for temporary licensing.*

I have read Minnesota Statutes, section 148.5161 and will provide supervision consistent with subd. 3. I understand that a temporary license expires 90 days from the date of issuance. Furthermore, I understand that I am the responsible supervisor for the above applicant until the Minnesota Department of Health receives my written and signed statement that I wish to cease supervision or until expiration of temporary licensing.

I have read and understand the instructions for this application process.

Supervisor's Signature | Date