

Iowa Board of Hearing Aid Specialists
Iowa Department of Public Health – Bureau of Professional Licensure
Lucas State Office Building, 5th Floor, Des Moines, IA 50319-0075

**Hearing Aid Specialist – Temporary Permit
Schedule for Supervision Form**

1. Name Temporary Permit Applicant: _____
2. Applicant's Address: _____
3. Applicant's City, State and Zip: _____
4. Name of Supervisor: _____ Supervisor License #: _____
5. Supervisor's Business Name: _____
6. Supervisor's Business Address: _____
7. Supervisor's City, State and Zip: _____

Supervision Scheduleⁱ

8. Describe the type of supervision to be provided during the first 90 days: _____
Estimated time: (required min. = 20 hours/ week direct supervision) _____
9. Describe the type of supervision to be provided after the first 90 days: _____
Estimated time: (required min. = 20 hours/ week direct supervision) _____
10. List of subjects to be covered during training: _____

11. Books and materials to be used for training: _____

Supervision Complete Attestation

The supervision is complete and followed the training plan set forth above.

Temporary Permit Applicant's Signature: _____ Date: _____

Supervisor's Signature: _____ Date: _____

ⁱ To complete this supervision schedule, refer to the Competency Model in the IHS Study Guide and the requirements of Iowa Administrative Code 645—121.2 and 645—121.3.