

**IDAHO SPEECH, HEARING AND COMMUNICATION SERVICES LICENSURE  
BOARD**

Idaho Bureau of Occupational Licenses  
700 West State Street, Boise, 83702 or  
PO Box 83720, Boise, ID 83720-0063  
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**HEARING AID DEALER AND FITTER**

**PROVISIONAL PERMIT HOLDER**

**Quarterly Report**

Instructions for Quarterly Reporting

Each Quarter the HAD Provisional Permit Holder shall submit a written report to the Idaho Speech, Hearing and Communication Services Board indicating what has been done toward completing the training as required by Rule 450.03.d of the Speech, Hearing and Communication Services Rules for Idaho. The reports are due as stated on the report form.

Complete quarterly reports will include:

\_\_ All sales and fittings made.

\_\_ Copy of all test results and hearing aid orders including audiograms, and instrument and specifications with copies of the order on all persons tested and fitted during the quarter. The names, addresses and phone numbers of each person must be blacked out. Please use a numbering system to distinguish the individual orders. Attachments of audiograms and orders with the instrument fit specifications must be in the order of appearance on the quarterly report form.

\_\_ The supervisor's summary or log of supervision contacts. The summary shall include a statement of changes made in orders, discrepancies noted on orders or on audiograms, and will list corrective actions taken in that regard.

\_\_ The quarterly report form is to be signed by both the trainee and the supervisor before a Notary Public.

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**HEARING AID DEALER AND FITTER**  
**TEMPORARY PERMIT HOLDER**

**Quarterly Report**

<u>Check Quarter</u>	<u>Due on or Before</u>
<input type="checkbox"/> 1 - JAN., FEB., MARCH	APRIL 10
<input type="checkbox"/> 2 - APRIL, MAY, JUNE	JULY 10
<input type="checkbox"/> 3 - JULY, AUG., SEPT.	OCT. 10
<input type="checkbox"/> 4 - OCT., NOV., DEC.	JAN. 10

NAME \_\_\_\_\_ Temporary Permit # \_\_\_\_\_

SUPERVISOR \_\_\_\_\_ NAME OF BUSINESS \_\_\_\_\_

IF THE COMPLETE QUARTERLY REPORTS ARE NOT RECEIVED BY THE 10<sup>TH</sup> OF THE MONTH FOLLOWING THE THREE MONTH PERIOD, THE PROVISIONAL PERMIT WILL BE TERMINATED.

The following is a supervisor's checklist of permit holder's strengths and needs during direct supervision visits during this quarter.

1. Shows good knowledge base for therapies observed. —
2. He/She shows integrity for professional ethics —
3. Therapy materials are well-prepared. —
4. Documentation is appropriate. —
5. Permit Holder conducts self in professional manner —
6. He/She provides appropriate feedback to client —
7. Permit Holder is punctual and accurate in timing sessions —
8. Therapy is age-appropriate and research-based —
9. Activity reflects intervention toward a measurable goal —

**SUPERVISOR'S SUMMARY** (The summary shall include a statement of changes made in orders, discrepancies noted on orders or on audiograms, and will list corrective actions taken in that regard.)

(IF MORE ROOM IS NEEDED PLEASE ATTACH ADDITIONAL PAGES)

I hereby declare that \_\_\_\_\_ has completed all training assignments for this quarter.

\_\_\_\_\_  
Signature of Supervisor

\_\_\_\_\_  
Signature of Permit Holder

\_\_\_\_\_  
License Number of Supervisor

State of \_\_\_\_\_, County of \_\_\_\_\_, ss.

Subscribed and sworn before me this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_

(seal)

\_\_\_\_\_  
Notary Public Official Signature  
My Commission Expires \_\_\_\_\_

