



CANNON BUILDING
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STATE OF DELAWARE

**BOARD OF SPEECH PATHOLOGISTS,
AUDIOLOGISTS AND HEARING AID DISPENSERS**

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HEARING AID DISPENSER SUPERVISORY REPORT

INSTRUCTIONS

Supervisors are to use this reporting form to conduct formal bimonthly evaluations of their Hearing Aid Dispenser trainee's performance and progress in completing all required subjects during the mandatory six-month training period. The supervisor will sign and submit this report **at the end of the training period** mailed directly to the Board office, at the address above. **Trainee – Enter your Application ID:** _____

TRAINEE & SUPERVISOR INFORMATION

1. Trainee Name: _____ Email: _____
2. Supervisor Name: _____ Delaware License: O ___ - _____

TRAINING SETTING & PERIOD INFORMATION

3. Enter the following information about the facility where the training will take place:
Business Name: _____
Address: _____
4. Expected Supervisory Period: From (month/day/year): _____ To (month/day/year): _____

EVALUATION - If you have additional comments, please enclose a statement with this form.

Months 1 and 2:

- | | |
|---|--|
| <ol style="list-style-type: none"> 1. Oscopic examination (e.g., importance of landmarks, visualization of tympanic membrane, cerumen, exotoses, etc.) 2. Hearing screenings, loudness discomfort measurements, speech thresholds and discrimination, air and bone conduction pure tone assessment and date recording 3. Routine instrument sterilization and universal precautions 4. Case history 5. Warning Signs Indicating the Need for Medical Attention <ul style="list-style-type: none"> • Visible congenital or traumatic deformity of the ear • History of active drainage from the ear within the previous 90 days • History of sudden or rapidly progressive hearing loss within the previous 90 days • Acute or chronic dizziness • Unilateral hearing loss of sudden or recent onset within the previous 90 days • Audiometric air-bone gap equal to or greater than 15 decibels at 500 hertz (hz), 1,000 hz, and 2,000 hz | <ul style="list-style-type: none"> • Visible evidence of significant cerumen accumulation for a foreign body in the ear canal. • Pain or discomfort in the ear |
|---|--|
-
- Evaluation | Months 1 and 2**

5 = excellent 4 = very good 3 = good
2 = satisfactory 1 = poor

Please check one:
- | | |
|----|--|
| 1. | 5 <input type="checkbox"/> 4 <input type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 1 <input type="checkbox"/> |
| 2. | 5 <input type="checkbox"/> 4 <input type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 1 <input type="checkbox"/> |
| 3. | 5 <input type="checkbox"/> 4 <input type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 1 <input type="checkbox"/> |
| 4. | 5 <input type="checkbox"/> 4 <input type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 1 <input type="checkbox"/> |
| 5. | 5 <input type="checkbox"/> 4 <input type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 1 <input type="checkbox"/> |

Months 3 and 4:

1. Basic hearing aid maintenance (e.g., replacing battery doors, cleaning mics and receivers, adjusting battery contacts, etc.)
2. **Ear mold impressions techniques (e.g., visual inspection, otoblock use, syringing technique, etc.)**
3. Counseling techniques (e.g. explaining results to clients, making appropriate recommendations, medical referral indicators, etc.)
4. Demonstrate understanding of hearing aid manufactures specifications
5. Electroacoustic analysis of hearing aids

Evaluation | Months 3 and 4

5 = excellent 4 = very good 3 = good
2 = satisfactory 1 = poor

Please check one:

1. 5 4 3 2 1
2. 5 4 3 2 1
3. 5 4 3 2 1
4. 5 4 3 2 1
5. 5 4 3 2 1

Months 5 and 6:

1. Biologic and electroacoustic assessment of the audiometer
2. Real ear measurement (if employer has this capability)
3. Assist in fitting hearing aids

Evaluation | Months 5 and 6

5 = excellent 4 = very good 3 = good
2 = satisfactory 1 = poor

Please check one:

1. 5 4 3 2 1
2. 5 4 3 2 1
3. 5 4 3 2 1

AFFIDAVIT

Being sworn and under oath, I verify that the above-named trainee has completed all training requirements under my supervision, and that I have held an active Delaware Hearing Aid Dispenser's license at all times during the training period.

Signature of Sponsor/Supervisor: _____ **Date:** _____

City of _____ County of _____

Sworn to before me and subscribed in my presence this _____ day of _____, 2_____.

Signature of Notary: _____

SEAL

My Commission Expires: _____