State of Ohio

John R. Kasich
Governor

Hearing Aid Dealers and Fitters Licensing Board

BUSINESS DUPLICATE LICENSE

Sections 4747.01, 4747.15 inclusive and 4747.99 Ohio Revised Code

PRINT in ink.

BUSINESS NAME	**Circle any that apply:** **Firm Partnership Corporation Association** **LICENSE NO. _____**	**DATE OF APPLICATION**
DBAs/Trade Names	**Federal Employer ID No. (EIN) _____** **Secretary of State Corporation Registration No. _____**	
PRIMARY OFFICE ADDRESS	**CITY/STATE**	**ZIP**
EMAIL	**PHONE**	
MAILING ADDRESS FOR DUPLICATES ***(if different than primary address)***	**Business Owner Name/Address**	**Business Owner Phone**
Business Owner Email	**ALL WEBSITE(S) of this Licensee**	

Since applying for or renewing the named Business Licensee's current Ohio Hearing Aid Dealers & Fitters license:

Has the named Business Licensee and/or its owner/agent acquired any new license(s) from any state, country, province or U.S. Territory?
☐**Yes** ☐**No** If yes, license number(s), Location(s) and Licensing Entity(s) _____

Has the named Business Licensee and/or its owner/agent had **any** license denied, revoked, suspended or restricted in any way by Ohio, another state, the U.S., another country, province or U.S. Territory?
☐**Yes** ☐**No** If yes, list date(s), offense(s), and restricting entity(s) _____
Attach a detailed, written explanation AND a copy of the Action from the Licensing Entity.

Has the named Business Licensee and/or its owner/agent been convicted of a felony or misdemeanor other than minor traffic violations?
☐**Yes** ☐**No** If yes, list County, Court, Case Number, Date _____
Attach a detailed, written explanation AND a CERTIFIED copy of the Court Record of Conviction and Sentencing.

For Board Use Only

Number of Duplicates Requested _____

X $16.00 each = Total Fees Enclosed $_____

Enclose a check or money order, payable to "Treasurer – State of Ohio"

- MORE/SIGNATURE REQUIRED ON REVERSE SIDE -

REV CODE 1262

Satellite Office Locations/Contacts for NEW or CHANGED location(s):

(For your convenience – a computer-generated document providing all requested information on this page is acceptable.)

Location Business NAME, Address/City/State/Zip	**Contact Name/Phone/Email** *(if different for each location)*

ALL Individuals Licensed to Fit/Sell Hearing Aids - Employed by or sub-contracted with Business Licensee:

Name - ***PRINT***	**License or Permit Number** **Type: HAD/F, Audiologist, Physician?**	**PRIMARY Work location**

Any false statement contained in this application is sufficient grounds for denial or revocation of license.

Ohio Revised Code 4747.12, 4747.14

_____ _____

Signature of Business Owner/Agent ***Date***

MAIL TO:

Ohio Hearing Aid Dealers and Fitters Licensing Board

PO Box 15278, Columbus OH 43215-0278

Questions? Call or write: 614-466-5215 hearing@odh.ohio.gov