HD01157F Rev. 11/2022

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

APPLICATION FOR NEW PRESCRIPTION HEARING AID DEALER/ REGISTRATION

HEARING AID SALES REGISTRATION LAW (HASR Law, ACT of 1976, No. 262)

This is NOT RENEWAL FORM

Type or print all information. Use "Not Applicable" (N/A) where appropriate. Pay fee by check or money order payable to "Pennsylvania Department of Health.", or credit card payment. DO NOT SEND CASH. Complete and return application along with correct fee to:

Pennsylvania Department of Health, Hearing Aid Program, 2525 North 7th Street, Harrisburg PA 17110 or

Email ra-ddc@pa.gov (emailed documents must be in PDF) or fax 717-231-4790.

The HASR Law does not apply to nor affect any physician, or audiologist licensed under appropriate licensing laws, or to an individual supervised by such physician, or audiologist, who does not directly or indirectly engage in the sale or offering for sale of prescription hearing aids.

Dealer Registration of business is required when such persons engage in the sale or offering for sale of prescription hearing aids or their professional employees.

REGISTRATION FEES

Hearing Aid Dealer Registration (main PA office)……$200.00 (Pro-rated* between October 16-March 1- Fee is $100)
Branch Offices (per location)…..…… $10.00 EACH Separate location in Pennsylvania
(*Registration with -pro-rated fee will still expire on upcoming April 15th and need to be renewed.)

1. NAME OF BUSINESS: _____

DOING BUSINESS AS (**IF DIFFERENT FROM MAIN BUSINESS NAME)** _____

PHYSICAL PENNSYLVANIA LOCATION OF BUSINESS: _____

CITY/STATE/ZIPCODE: _____

TELEPHONE: _____ EMAIL:_____FAX:_____

2. HAVE YOU EVER HELD A DEALER REGISTRATION WITH THE PENNSYLVANIA DEPARTMENT OF HEALTH ?

NO _____ YES _____ (IF YES) WHEN ?_____ DEALER CERTIFICATE NO. _____

2. IS THIS A CHANGE OF OWNERSHIP (i.e Purchasing an existing facility)?

NO _____ YES _____ (IF YES) WHEN ?_____ DEALER CERTIFICATE NO. _____

Note: If only partial purchase (i.e. branch office only) please note Dealer Branch Certificate No. here _____

3. BUSINESS MAILING ADDRESS AND CONTACT INFORMATION: (IF DIFFERENT FROM ABOVE)

ADDRESS: _____

CITY/STATE/ZIP CODE: _____

TELEPHONE: _____ FAX: _____

4. DESCRIBE TYPE OF OWNERSHIP (CORPORATION, PARTNERSHIP, SOLE PROPRIETORSHIP, LLC, ETC.) IF INCORPORATED, LIST DATE AND STATE OF INCORPORATION

_____

4b. OWNERSHIP NAME(S): **INDIVIDUAL, PARTNERS, OR CORPORATE OFFICERS WITH TITLE. BE SPECIFIC.**
(USE ADDITIONAL SHEET IF NEEDED**)**

NAME TITLE NAME TITLE

_____

_____

4c. ATTACH CERTIFIED COPIES OF DOCUMENTATION TO DO BUSINESS (e.g. ARTICLES OF INCORPORATION, CERTIFICATE OF ORGANIZATION, FICTITIOUS NAME REGISTRATION, FOREIGN REGISTRATIONS, ETC.) FROM PENNSYLVANIA DEPARTMENT OF STATE (see www.dos.pa.gov) THAT SAID BUSINESS ENTITY IS REGISTERED TO DO BUSINESS IN PENNSYLVANIA.

4d. CHANGE OF OWNERSHIP (if this is a change of ownership from a previously existing registered dealership, please list business name & previous registration number)**. Attach agreement between purchasers regarding patient records and care.** Skip if not applicable

Previous Dealer registration # _____ under business name _____

5. NAMES OF ANY FITTER, AUDIOLOGIST, AND/OR PHYSICIAN FITTING AND SELLING HEARING AIDS UNDER THE AFOREMENTIONED BUSINESS ENTITY (NOTE: **AT LEAST ONE** PENNSYLVANIA PROFESSIONAL LICENSED/REGISTRATRANT IS REQUIRED ONSITE TO SELL/OVERSEE FACILTY)**. SEND COPIES OF CURRENT PA LICENSES WITH APPLICATION.** USE ADDITIONAL PAPER IF NECESSARY.

NAME	**PENNYLVANIA LICENSE/REGISTRATION NUMBER**	**DATE EXPIRES**
_____	_____	_____
_____	_____	_____
_____	_____	_____

6. BRANCH OFFICES UNDER THIS BUSINESS OWNERSHIP (OTHER LOCATIONS DIFFERENT FROM MAIN LOCATION USED TO FIT & SELL PRESCRIPTION HEARING AIDS) USE ADDITIONAL PAPER IF NECESSARY. SKIP IF NOT APPLICABLE.

NAME OF BUSINESS BRANCH 1: _____ NAME OF BUSINESS BRANCH 2_____

ADDRESS BRANCH 1 : _____ ADDRESS BRANCH 2 : _____

CITY/STATE/ZIP CODE: _____ CITY/STATE/ZIP CODE: _____

TELEPHONE: _____ FAX: _____ TELEPHONE: _____ FAX: _____

PROFESSIONAL IN CHARGE AT BRANCH OFFICE 1**:** **PROFESSIONAL IN CHARGE AT BRANCH OFFICE** 2**:**

NAME _____CERTIFICATE NO**. _____** **NAME _____**CERTIFICATE NO**. _____**

6. HAS APPLICANT, OR ANY OF THE OFFICERS, AGENTS OR EMPLOYEES OF THE ESTABLISHMENT/S EVER BEEN CONVICTED OF A CRIMINAL OFFENSE OR EVER HAD A LICENSE OR EQUIVALENT AUTHORIZATION PREVIOUSLY HELD FOR FITTING OR SALE OF HEARING AIDS, BEEN DENIED, SUSPENDED, REVOKED, RESTRICTED OR SUBJECTED TO ANY OTHER SANCTION FOR DISCIPLINARY REASONS BY ANY GOVERNMENT AUTHORITY?: (felonies & misdemeanors. Convictions include a verdict of guilty, a guilty plea of nolo contendere).

INCLUDE STATE OR FEDERAL CRIMINAL BACKGROUND OF OFFICERS/OWNERS WITH APPLICATION.

□ **YES** (IF YES, LIST ALL (IN DETAIL) CONVICTIONS OF FELONIES OR MISDEMEANORS – LIST EXACT CRIME, COUNTY WHERECONVICTED, DATE OF CONVICTION AND THE RESULTING PENALTY IMPOSED).DESCRIBE FULLY ANY OTHER ACTIONS LISTED ABOVE, USING ADDITIONAL PAPER IF NECESSARY.

□ **NO**

7. PAYMENT: Attach check or money order or complete this section if paying by CREDIT CARD :
PLEASE CIRCLE ONE(VISA MC DISCOVER AE)

_ _ _ _- _ _ _ _- _ _ _ _-_ _ _ _ EXP DATE _ _/_ _ AMOUNT $ _____

Security Code _ _ _ (3 Digit Code or number on back of credit card located in the signature block, last 3 digits only)

I certify that ALL information provided on this application, and any documentation submitted with it, is all true and correct to the best of my knowledge. I certify that I have reviewed applicable laws related to the fitting and sale of prescription hearing aids in Pennsylvania and understand requirements related to such fitting and sales.

_____

OWNER OR OFFICER SIGNATURE DATE