



**HEARING AID DISPENSER PROGRAM EXPERIENCE ATTESTATION
FORM**

Full Legal Name: _____

I hereby attest under penalty of perjury the below information is true and complete as of the date signed below.

Select the statement that applies to you:

_____ I **have completed** 1000 hours of supervised training while licensed as a hearing aid dispenser trainee as required by [MCA 37-16-402](#) and [24.151.504 \(1\)](#).

_____ I have **not completed** the 1000 hours of supervised training. I am licensed in another state and request the department determine whether the deficiency can be addressed by my actual qualifications and work experience as per [MCA 37-1-304](#) if the qualifications are not substantially equivalent.

Signature

Date