

ASSOCIATION OF HEARING INSTRUMENT PRACTITIONERS OF ONTARIO

APPLICATION FOR CERUMEN MANAGEMENT CERTIFICATION

I WISH TO ENROLL FOR:	CERUMEN MAN	AGEMENT CERTII	FICATION		
I AM APPLYING FOR:	ADDITIONAL MO	ONITOR FOR CERU	IMEN MANAGEMI	ENT CERTIFICATION	
TO BE COMPLETED	BY THE APPLICANT	– Cerumen Mai	nagement		
LAST NAME		FIRST NAME	FIRST NAME		
HOME ADDRESS		CITY	PROV	POSTAL CODE	
CLINIC (FULL) NAME A	ND ADDRESS				
CITY		PROVINCE		POSTAL CODE	
HOME PHONE	BUS PHONE	EM	AIL		
SIGNATURE		DA	TE		
This clinical experience mu or H.I.D.) who is an AHIP The above noted Monitor n Specialist or Hearing Instr	BY THE MONITOR — ust be monitored by a Hearin member in good standing; a nust also be full member wit rument Dispense or an Audio itor no more than TWO (2) a	ng Instrument Spec and/or an Audiolog h a minimum of TV ologist, and minimu	ialist or Hearing I ist, Reg. CASLPO VO years' experien ım TWO years ceri	member in good standing. ace as a Hearing Instrument	
LAST NAME		FIRST NAME			
CLINIC NAME AND AD	DRESS				
CITY		PROVINCE		POSTAL CODE	
BUS PHONE		EMAIL			
AHIP/CASLPO #		CERUMEN CERTIFICATE COMPLETION DATE: ATTACH CERTIFICATE TO APPLICATION:			
SIGNATURE		DATE			