ASSOCIATION OF HEARING INSTRUMENT PRACTITIONERS OF ONTARIO

Membership Application 2026

ASSOCIATE MEMBER (Non voting/non practicing) **$850.00**

Payment: Cheque_____Amex/MC/ Visa_____ Exp_____ CVV code____

A. APPLICANT INFORMATION

PLEASE PRINT

☐ Mr. ☐ Mrs. ☐ Miss. ☐ Ms. ☐ Dr.

_____ _____ _____

LAST NAME FIRST NAME MIDDLE NAME

_____

COMPLETE HOME ADDRESS (Incl. Postal Code)

_____ _____ _____

HOME /CELL TELEPHONE # WORK TELEPHONE # DATE OF BIRTH (DD/MM/YYYY)

_____

EMPLOYMENT FULL & COMPLETE NAME, ADDRESS AND TELEPHONE NUMBER (Incl. Postal Code)

_____

MEMBER CONTACT EMAIL ADDRESS*(mandatory)***

ARE YOU OR YOUR EMPLOYER CURRENTLY AN ASSISTIVE DEVICES PROGRAM VENDOR? ☐ YES ☐ NO

B. EDUCATION

PLEASE INDICATE ANY COLLEGE OR UNIVERSITY EDUCATION AQUIRED OR ATTENDING AT PRESENT.

NAME OF INSTITUTE	PROVINCE (LOCATION)	YEARS COMPLETED	DEGREE	MAJOR SUBJECTS	COMPLETION DATE

C. EMPLOYMENT

BEGIN WITH YOUR PRESENT PLACE OF EMPLOYMENT. LIST **EVERY** POSITION HELD FOR THE PAST 5 YEARS

NAME & COMPLETE ADDRESS OF EMPLOYER	DATES OF EMPLOYEMENT FROM TO	DUTIES	FULL OR PART TIME	NAME & TITLE OF SUPERVISOR	REASON FOR LEAVING

D. QUALIFICATIONS

Length of experience actively and principally engaged in the practice of the testing of hearing and the selection, and or fitting and dispensing of hearing instruments.

_____ _____
YEARS MONTHS

E. REFERENCES

BUSINESS REFERENCES:

1. COMPANY_____

ADDRESS_____

PHONE _____

2. COMPANY_____

ADDRESS_____

PHONE _____

PROFESSIONAL REFERENCES:

1. COMPANY_____

ADDRESS_____

PHONE _____

APPLICANT'S AFFIDAVIT

I hereby make application for membership in the Association of Hearing Instrument Practitioners of Ontario, and if accepted, I will abide by the By-Laws, Policies and Code of Ethics as established by the Association. I understand that failure to do this may be cause for cancellation and recall of my Certificate and expulsion from the Association. I further understand that continuance of my Membership is conditional upon my meeting the requirements for annual renewal of my Certificate.
I acknowledge that the Certificate of Membership is the property of the Association and that it will be returned upon demand by the Association.

_____ _____
SIGNATURE **DATE**

PLEASE MAIL OR FAX COMPLETED APPLICATION FORM TO:
ASSOCIATION OF HEARING INSTRUMENT PACTITIONERS OF ONTARIO, 55 MARY STREET WEST, SUITE # 211, LINDSAY, ONTARIO, K9V 5Z6. FAX 1-844-688-5583
PLEASE INCLUDE PAYMENT OF YOUR MEMBERSHIP DUES.
PROCESSING YOUR APPLICATION MAY TAKE UP TO 2-3 WEEKS. WHEN YOUR APPLICATION IS APPROVED, YOU WILL RECEIVE OFFICIAL NOTIFICATION BY MAIL FROM AHIP.
FAILURE TO COMPLETE THE APPLICATION WILL DELAY PROCESSING

THIS SECTION FOR OFFICE USE ONLY- DO NOT WRITE IN THE SPACE BELOW

DATE RECEIVED: _____ **APPROVED BY:** _____

APPROVAL DATE: _____ **MEMBERSHIP #:** _____