

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 705 878-4110 or 1-844-688-5583

PLEASE INCLUDE PROOF OF GRADUATION (CERTIFICATE) AND PAYMENT OF YOUR MEMBERSHIP DUES AND PROOF OF \$2,000,000 PROFESSIONAL LIABILITY INSURANCE.
PROCESSING YOUR APPLICATION MAY TAKE UP TO 2-3 WEEKS. WHEN YOUR APPLICATION IS APPROVED, YOU WILL RECEIVE OFFICIAL NOTIFICATION BY MAIL FROM AHIP.

AHIP WILL NOT CONSIDER ANY APPLICATIONS THAT ARE NOT COMPLETE.

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

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

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