



Paul R. LePage

Governor

STATE OF MAINE
DEPARTMENT OF PROFESSIONAL
AND FINANCIAL REGULATION
Board of Speech, Audiology and Hearing
35 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0035

Anne L. Head

Commissioner

REQUEST FOR EXAMINATION

To request examination, please complete the information requested below and return this form with a fully completed Verification of Trainee Practicum Form and your signed training log by mail to the Board at the above address. Please note that trainees must have completed a minimum seven hundred fifty (750) hours in the practice of dealing in and fitting of hearing aids during a period of not fewer than six (6) months nor more than eighteen (18) months.

Applicant Information (please print)
Name of Applicant:
Mailing Address:
City: State: Zip Code:
Telephone Number: Fax Number:
E-mail Address:

Make the appropriate selection(s) below.
Written Examination
Once your hours have been reviewed and approved, you will receive additional information and registration instructions from the International Hearing Society.
Practical Examination
In addition to the form and log requested above, I have also submitted an examination fee of \$50.00. Please make checks/money orders payable to IHS.
Once your payment has been received and your hours have been reviewed and approved, you will receive an examination admission notice confirming the date and time of your examination.



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OFFICE PHONE: (207)624-8626

TTY USERS CALL MAINE RELAY 711
OFFICES LOCATED AT: 76 NORTHERN AVENUE,
GARDINER, MAINE

FAX: (207)624-8637



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ACCOMMODATION REQUEST FORM

The information requested below and any documentation regarding your disability and your need for accommodation in testing will be considered strictly confidential and will not be shared with any outside source without your express written permission. **Please note:** Some accommodation requests may require additional documentation (see next page).

Name: _____

Mailing Address: _____

City: _____

State: _____

Zip Code: _____

Telephone (include area code): _____

Social Security Number: _____

Accommodations Requested for the _____ Examination.

- Check all that apply:
- Accessible Testing Site
- Separate Testing Site
- Braille
- Large Print
- Tape
- Reader as Accommodation for Visual Impairment
- Scribe/Amanuensis as Accommodation for Visual or Motor Impairment
- Reader as Accommodation for Learning Disability
- Scribe/Amanuensis as Accommodation for Learning
- Sign Language Interpreter
- Extended Time
 - Time-and-a-half
 - Double time
 - More than double time (specify) _____
- Use of Computer or Other Adaptive Equipment (specify) _____
- Other: _____

SIGNATURE: _____ DATE: _____



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Applicant's Name: _____

DOCUMENTATION OF DISABILITY NEEDS

If you have a learning disability, a psychological disability, or other hidden disability that requires an accommodation in testing, please have this section completed by an appropriate professional (education professional, doctor, psychologist, psychiatrist) to certify that your disabling condition requires the requested test accommodation.

If you have existing documentation of having the same or similar accommodation provided to you in another test situation, you may submit such documentation instead of having this portion of the form completed.

I have known _____ since _____ in my capacity as a
(test applicant) (date)

(professional title)

The applicant has discussed with me the nature of the test to be administered. It is my opinion that because of this applicant's disability, he/she should be accommodated by providing the following (check all that apply):

- Taped test
- Large print test
- Reader
- Scribe/amanuensis
- Extended time
 - Time-and-a-half
 - Double time
 - More that double time (please justify) _____
- Separate Testing Area
- Use of Computer or Other Adaptive Equipment (please specify) _____
- Other (please specify) _____

SIGNATURE: _____ TITLE: _____

DATE _____ LICENSE # (if applicable) _____



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