



GOVERNMENT OF THE DISTRICT OF COLUMBIA  
 DEPARTMENT OF HEALTH  
 HEALTH REGULATIONS AND LICENSING ADMINISTRATION  
 PHARMACEUTICAL CONTROL DIVISION  
 899 NORTH CAPITOL STREET, NE  
 WASHINGTON, DC 20002

APPLICATION FOR REGISTRATION PERMIT HEARING AID

1. \_\_\_\_\_  
 NAME OF APPLICANT(S): \_\_\_\_\_ Phone Number \_\_\_\_\_

2. \_\_\_\_\_  
 NAME: \_\_\_\_\_ Fax Number \_\_\_\_\_  
 \_\_\_\_\_ E-Mail \_\_\_\_\_

3. \_\_\_\_\_  
 ADDRESS: Street and Number City State Zip Code

4. \_\_\_\_\_

5. \_\_\_\_\_  
 TRADE NAME: \_\_\_\_\_ Phone Number \_\_\_\_\_

6. \_\_\_\_\_  
 ADDRESS OF PREMISES APPLIED FOR: \_\_\_\_\_ Zip Code \_\_\_\_\_

7. \_\_\_\_\_  
 D.C. WARD NO. \_\_\_\_\_

8. \_\_\_\_\_  
 Certificate of Occupancy No. \_\_\_\_\_

9. Indicate whether a  
 CHANGE OF OWNERSHIP  CHANGE OF LOCATION  NEW APPLICATION  RENEWAL #

10. If change of Ownership, give previous name: \_\_\_\_\_  
 \_\_\_\_\_

11. If New Location, give:  
 Date Ready for Inspection \_\_\_\_\_  
 Date of Opening \_\_\_\_\_

12. NAME OF CORPORATION: \_\_\_\_\_ Phone Number \_\_\_\_\_

OFFICE ADDRESS: \_\_\_\_\_ City State Zip Code

NAME OF BUSINESS \_\_\_\_\_

ADDRESS OF BUSINESS \_\_\_\_\_ Zip Code \_\_\_\_\_

13. If Corporation, list Officers and Address

President: \_\_\_\_\_

Vice President: \_\_\_\_\_

Secretary: \_\_\_\_\_

Treasurer \_\_\_\_\_

14. If Non D.C. Corporation and/or Non D.C.  
 Resident: Applicant's D.C. Agent  
 Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_

15. Has applicant(s) been found guilty of fraudulent hearing aid practices or advertising?  YES  NO  
 If answer to above question is Yes, please attach supplemental sheet with explanation.

I CERTIFY THAT ALL OF THE STATEMENTS MADE BY ME ARE TRUE, COMPLETE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF, AND ARE MADE IN GOOD FAITH.

16. Signature of Applicant \_\_\_\_\_ 17. Date \_\_\_\_\_