



DEPARTMENT OF HEALTH
 HEALTH REGULATIONS AND LICENSING ADMINISTRATION
 PHARMACEUTICAL CONTROL
 899 North Capitol St. NE., 2nd FLOOR
 WASHINGTON, D.C. 20002

APPLICATION FOR REGISTRATION PERMIT Hearing Aid Dealers

1. NAME OF APPLICANT(S): _____ Phone Number _____

2. NAME: _____ Phone Number _____

3. ADDRESS: _____
 Street and Number City State Zip Code

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

10. If change of Owership, 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 _____