



GOVERNMENT OF THE DISTRICT OF COLUMBIA
 DEPARTMENT OF HEALTH
 HEALTH REGULATIONS AND LICENSING ADMINISTRATION
DOH – Pharmacy
P.O. Box 37803
Washington D.C. 20013



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 _____