

Loma Linda University Medical Center  
Allied Health Professional  
Audiologist Job Description

Practitioner Name: \_\_\_\_\_

Practice Specialty Requested: \_\_\_\_\_ License # \_\_\_\_\_

Supervising Physician Name: \_\_\_\_\_ Specialty \_\_\_\_\_

**Requirements:**

- Masters degree in Audiology from an accredited program approved by the American Speech and Hearing Assoc **and**
- California State Audiologist license **and**
- Able to bill for services rendered

**Responsibilities:** Diagnostic evaluation for hearing loss, tinnitus, vertigo and aural rehabilitation including:

- Diagnostic audiograms
- Tympanograms
- Hearing aid evaluations
- Electronystagmyography
- Evoked potential audiometry
- Pediatric diagnostics
- Pre-chemo evaluations
- Cochlear implant fitting and modification
- Counseling patients regarding test results
- Reporting to the referral source
- Intraoperative Nerve Monitoring

Audiology tests are performed in a special sound treated room for improved test reliability. Hospital inpatients may have some of these tests performed at bedside for logistical reasons. Audiologists do not require supervision for any of their test procedures or techniques.

**Acknowledgment of AHP**

In accordance with the provisions of Section 3055 of the Business and Professions Code, I am licensed as an Audiologist in the State of California and subject to the Licensing Board rules and regulations. I acknowledge that I have received a copy of the Medical Staff Bylaws and Rules and Regulations, and agree to be bound by the terms of the Bylaws of the Medical Staff and of the hospital, and all other manuals and policies relevant to practice privileges at Loma Linda University Medical Center under the AHP category, and JCAHO and State Standards.

I have requested only those specific practice privileges for which by education, training, current experience and demonstrated performance for which I am qualified and wish to exercise at Loma Linda University Medical Center, Inc.; **and**

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Supervising Physician Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Service Chief Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Credentials Committee Chair

\_\_\_\_\_  
Date

\_\_\_\_\_  
Medical Staff Executive Committee Chair

\_\_\_\_\_  
Date

\_\_\_\_\_  
Governing Board Officer/Designee

\_\_\_\_\_  
Date