UNIVERSITY OF THE
PACIFIC
HEARING & BALANCE CENTER

Medical Clearance

(to be completed by the physician)

I have medically evaluated _____'s hearing loss and this person may be considered a candidate for a hearing aid.

Patient's Name

Physician's Signature _____

Physician's Name (print) _____

Address _____

City _____ Street _____

Phone _____ Fax _____

Date _____