Medical Clearance

(to be completed by the physician)

_____ has been evaluated and is considered a candidate for a hearing aid(s). The hearing loss is not due to a temporary, correctable physical condition. There are no contraindications to hearing aid candidacy. Please complete the bottom portion of this form and return it to our clinic at your earliest convenience.

Fax: (209) 932-4112

Thank you for your assistance. If you have any questions, please contact us at any time at (209) 946-7378.

Physician's Signature _____

Physician's Name (print) _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____

Date _____