

## 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 \_\_\_\_\_