Medical Clearance

Name:_____

Age:_____ **Birth Date:**_____

Address:_____

City:_____

State:_____ **Zip:**_____

TO BE COMPLETED BY A PHYSICIAN

The above named patient's hearing loss has been medically evaluated. He/She ears are free and clear of wax, infection and obstruction. He/She is considered to be a candidate for hearing aids. Medical clearance is granted for the purpose of wearing hearings aids:

_____**Yes** _____**No**

If medical clearance is not granted, please specify reasons for denial.

Date:_____ **X**_____
Physician

Clinic or Hospital Name and Phone Number

_____

_____

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