START HEARING

Medical Clearance Form

Patient Name: _____ Date of Birth: _____

Date of Examination: _____

After thorough examination, I have determined that the above named patient is medically cleared for hearing aids.

If you need anything further from me, please contact me at the address or phone number listed below.

Examining Physician / Clinic Information:

Physician Signature: _____

Physician Printed Name: _____

Physician NPI Number: _____

Facility Name: _____

Address: _____

City, State, Zip: _____

Phone Number: _____