Provider Recommendation for: ______________________________

Print Patient's Name

This section must be completed by the hearing professional who performed the hearing test.
You must include a copy of that current hearing test (audiogram).
The Lighthouse does not pay for hearing tests.

Business Name: ____

Name and Title of Hearing Professional: ____

Phone Number: ______________________________ Fax Number: __________________________________

Address: ____ City: ________________________

State: ______________ Zip Code: ___________ **Email Address:** ____________________________________

Please specify degree of hearing loss: Mild Moderate Moderately Severe Severe Profound

Circle the type of hearing aids recommended:

Right Ear: None RIC/BTE ITE BI CROS

Left Ear: None RIC/BTE ITE BI CROS

Do you require Medical Clearance for this patient? Yes No

If no, patient needs to sign medical waiver on the bottom of this page.

Is this facility a Lighthouse Provider? Yes No

If no, patient needs to follow instructions on Page 9.

If no, are you interested in becoming a Lighthouse Provider? Yes No

Contact us at 404.325.3630 or visit www.LighthouseGeorgia.org for more information.

Medical Waiver

I have been advised by ____________________________________ (audiologist/hearing aid dispenser) that the Food and Drug Administration has determined that my best health interest would be served if I had a medical evaluation by a licensed physician (preferably a physician who specializes in disease of the ear) before obtaining a hearing aid. **I choose not to have a medical evaluation before obtaining a hearing aid.**

____ ____/____/____

Signature of Applicant Date

Medical Clearance

I certify that _________________________ (**applicant name**) was medically examined on ___/____/___ and may be considered a candidate for hearing aid use.***Must be signed and dated by a licensed physician (M.D.)***

____ ____/____/____

Signature of M.D. Date

____

Name of M.D. (Please Print)