



## MEDICAL CLEARANCE FOR HEARING AIDS

The following Patient is medically cleared for the use of hearing aids.

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Physician Name: \_\_\_\_\_

Physician Signature: \_\_\_\_\_

Date: \_\_\_\_\_

---

**Please Fax Back To**

**517-669-8070**

---