Verification of Hearing Impairment (Supplementary Information Request)

Patient Information	
Legal Name:	Date of Birth (MM/DD/YYYY):

1. **Please check one:** I certify that I am a ☐ **Certified Audiologist** with expertise in diagnosing and/or treating the condition(s) indicated below.

2. Indicate your **formal diagnosis**:

Formal Diagnosis	**Date of Onset**	**Expected to Persist ☑**
		☐ Less than 2 years ☐ 2+ years ☐ Not expected to improve

3. Indicate the Applicant's level of hearing loss **in each ear**:

Left:	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ Profound
Right:	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ Profound

4. Check **all** that apply:

☐ The Applicant uses **aided hearing** (specify make/model): _____

☐ *Even with aided hearing*, the hearing loss **interferes with learning, working, and/or activities of daily living**

☐ I have attached a **recent audiogram** (required)

☐ May require amplification device in an educational/vocational setting (recommend make/model):

_____

4. Is there **anything else** you think we should know about the Applicant's medical condition (including recommendations for support)?

Certifying Medical Professional

*I certify that the information provided on this form is **accurate and current** to my knowledge and that the person identified in this assessment as "the Applicant" **experiences the impairments** I have indicated.*

Name of Certifying Medical Assessor:		Registration/Certificate#:
Specialty/Occupation of Medical Assessor:		Telephone Number:
Mailing Address:		Fax Number:
City/Town:	Province:	Postal Code:
Signature (in ink):		Date: