

**MEDICAL CLEARANCE FOR HEARING AID CANDIDACY**

PATIENT NAME: \_\_\_\_\_

The above patient has been medically evaluated and is considered a candidate for a hearing aid(s). The hearing loss is not due to a temporary, correctable physical condition. There are no contraindications to hearing aid candidacy.

Signed,

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician Name (Please print)