

Medical Clearance Form for iHEARtest

Patient Name*: _____ Phone Number: (____) _____
Address: _____ _____
E-mail Address*: _____
*required

It is in your best health interest to have a medical evaluation by a physician. This medical clearance form is required for individuals who have or suspect any of the following conditions:

- Visible deformity of the ear
- Current ear infection
- History of active drainage from the ear within the past 90 days
- Sudden or rapid progression of hearing loss within the past 90 days in one or both ears
- Acute or chronic dizziness
- Visible evidence of significant cerumen (ear wax) accumulation or a foreign body in the ear canal
- Pain or discomfort in the ear
- Individuals with poor dexterity, poor vision, or significant dementia, or other cognitive impairment
- Fluctuating hearing sensitivity
- Sudden onset or rapid worsening of tinnitus (ringing) within the past 90 days
- History of conductive or mixed hearing loss or ear surgery

<i>To be completed by a Physician</i>	
The following information relates to _____, a patient in my care. <i>Patient Name</i>	
I evaluated this patient's health within the last three months. This patient may be considered a candidate for a hearing test.	
_____ <i>Physician's Signature</i>	_____ <i>Date</i>
_____ <i>Phone</i>	

Fax: (510) 686-8560 **E-mail:** support@ihearmedical.com **Mail:** Customer Support, iHear Medical, Inc.
15250 Hesperian Blvd. Suite 102
San Leandro, CA 94578