iHEAR®

Medical Clearance Form for Hearing Aid

Patient Name: _____ **Phone Number:** (____) _____

Address: _____

_____

It is in your best health interest to have a medical evaluation by a physician before purchasing or using a hearing aid. We encourage you to have a medical evaluation and have your physician complete the form below.

To be completed by a Physician - This serves as a recommendation for hearing aid

The following information relates to _____, a patient in my care.
Patient Name

I evaluated this patient's hearing health within the last three months. This patient may be considered a candidate for hearing aids.

_____ _____
Physician's Signature *Date*

_____
Phone

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For any question about this form, you may contact iHear Medical, Inc.
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