



OFFICES • LLC
Hearing Resources for the
Northern Neck/Middle Peninsula

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***MEDICAL CLEARANCE
FOR HEARING AID CANDIDACY AND TESTING***

Patient's Name (Please Print) **DOB:** _____

The above patient has been medically evaluated and may be considered a candidate for a hearing aid(s). Please conduct audiological testing for diagnosis/treatment of hearing loss.

Physician's Name (PRINT) *NPI #*

Physician's Signature *Date*