

Medical Statement Options
(Choose One)

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)



Statement of Medical Waiver

(Age 18 and older only)

I have been advised by Diana Eshleman, AuD, All Generations Audiology, PLLC, that the Food and Drug Administration has determined that my best interest would be served if I had a medical evaluation by a licensed physician (preferably a physician who specializes in diseases of the ear) before purchasing a hearing aid. I do not wish a medical evaluation before purchasing a hearing aid.

I further understand that a copy of this statement will be kept on file by the named audiologist for a period of three years from this date, in accordance with the Food and Drug Administration regulations.

Signed,

Patient Signature

Date