



**Statement of Medical Waiver**

Date: 12/30/2012

Mr. Robert L. Smith  
4506 45th WY  
Mangonia Park, FL 33407

I have been advised by Alissa B. Howard, Au.D. (or other Hearing Health Care Practitioner \_\_\_\_\_) from Northwest Florida ENT that the Food and Drug Administration has determined that my best interest would be served if I have 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 clinician for a period of three years from this date, in accordance with the Food and Drug Administration regulations.

I am 18 years old or older.

Signature \_\_\_\_\_ Date \_\_\_\_\_