



**Medical Clearance Form**

to be completed by the Physician

Date: 12/30/2012

I have medically evaluated the hearing loss of Robert L. Smith and the patient may be considered a candidate for a hearing aid.

Physician Signature: \_\_\_\_\_

Date: \_\_\_\_\_

OR

**WAIVER OF MEDICAL CLEARANCE FOR HEARING AID USE**

To be completed and signed by the patient

I understand that it is in my best interest and recommendation of the Food and Drug Administration to receive a medical examination before acquisition of hearing aids. I choose not to receive a medical examination before acquiring hearing aids.

Patient Signature

\_\_\_\_\_

Date: \_\_\_\_\_