



## **MEDICAL CLEARANCE FORM**

*Patient Name:* \_\_\_\_\_

*Date of Birth:* \_\_\_\_\_

*The above patient may receive a hearing test, and depending on the outcome of the results, hearing aids*

\_\_\_\_\_  
*Physician Printed Name*

\_\_\_\_\_  
*Physician Signature*

\_\_\_\_\_  
*NPI#*

\_\_\_\_\_  
*Date*

**Please fax back to 630-908-5159**