Medical Clearance Form

Child applicants, 18 and younger, must have clearance from a physician to receive services from Miracle-Ear.® This form must be completed by a physician (M.D./D.O.) or nurse practitioner.

I have evaluated (print child or adult name): _____
and find that he/she has a hearing loss that makes him/her a candidate for a hearing aid, and that no medical contra-indications for amplification exist.

Date: _____

Physician Name (please print):_____

Physician Address: _____

_____

Physician Phone Number: _____

Signature of Physician: _____