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Medical Clearance Form

Date: _____

Patient Name: _____

Date of birth: _____

I have evaluated _____ for the use of amplification and find:

_____ No limitations- patient may be fitting in either ear with an appropriate
style hearing aid(s).

_____ Open venting hearing aid due to potential outer or middle ear pathologies in
right _____ left _____ Binaural _____ ear(s).

_____ Other: _____

ANY ADDITIONAL COMMENTS: _____

Sincerely, _____, MD

_____ MD

Signature

Please print or stamp name

