

HEARING LOSS CERTIFICATION

Telecommunications Assistance Program

Use of form: Completion of this form meets the requirements of s. 46.92, Wisconsin Statutes. Personally identifiable information on this form will be used to determine eligibility for services and will be used only for this purpose.

Name - Applicant (Last, First, Middle)	Telephone Number
Address - (Street)	Date Examined (mm/dd/yyyy)
Address - (City, State, Zip Code)	

I examined the person named above on the date shown and have found him / her to possess a hearing loss significant enough to be considered: (check one)

- Deaf
- Severely Hard of Hearing
- Hard of Hearing

Person Verifying Information

Name	Title (Use one of the titles listed below.)
Address - (Street)	
Address - (City, State, Zip Code)	Telephone Number
SIGNATURE - Person Verifying Information	Date Signed (mm/dd/yyyy)

Note: This certificate must be completed by one of the following:

1. Licensed physician
2. Certified audiologist
3. DVR counselor
4. Independent Living Center counselor
5. ODHH Regional Coordinator

TEPP Application Number: _____

Questions? Call 608-266-3118

Distribution: Mail completed copy to ODHH, Rm. 451, 1 West Wilson St., P.O. Box 7851, Madison, WI 53707-7851; or
Fax it to 608-266-3386.