Deaf and Hard of Hearing Advocacy Resource Center

www.dhharc.org

999 Pyramid Way
Sparks, NV 89431
775.355.8994 V/TTY
775.355.8996 Fax
775.434.0290 VP

2881 S. Valley View Blvd
Suite #13
Las Vegas, NV 89102
702.363.3323 V/TTY
702.685.0324 Fax
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TELECOMMUNICATION EQUPMENT DISTRIBUTION PROGRAM CERTIFICATION FORM

☐ **TTY** ☐ **Amplified Phone** ☐ **CapTel Phone**

Please mark your choice above

In order for the following applicant to be considered for the telecommunication equipment distribution program the applicant must have his/her audiologist/doctor/professional (listed below) complete this form.

You are required to bring or mail this completed form to the equipment distribution program nearest you. Once your application is approved and your equipment is ready to be picked up DHHARC will contact you to make an appointment to receive your equipment as well as the appropriate training.

Note: This form is to be filled out by a Physician, Surgeon, Vocational Rehabilitation Counselor, Speech Pathologist, Audiologist, or Authorized Agency Representative (please indicate title/position)

☐Applicant Name: _____
Last Name First Name Middle Initial

Check Type(s) of impairment(s) being certified: Hearing ☐ Speech ☐

I certify that the applicant has the following hearing loss:

☐Decibel Loss: _____ (Left ear) _____ (Right ear)

☐ Speech: In my opinion, I understand the applicant's speech ability to be:

____ Excellent
____ Average
____ Poor
____ Other:_____

Name: _____ Title/Position: _____

Address: _____ City: _____

_____ Zip code: _____

Phone :_(_____) _____ E-mail:_____

I certify that the above named person has the impairment(s) which severely restricts his/her receptive and/or expressive use of the telephone and qualifies for equipment provided under Nevada State Legislation. NRS 707.360

☐ Signature: _____ ☐ Date: _____