EAR Audiology, Inc.
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San Diego, CA 92130

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(760) 652-1652 fax
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Medical Clearance for Hearing Aids

Name of Patient ______________________

Age of Patient ______________________

Physician Name ______________________

Examination Date ______________________

Physician Address:

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Today's Date ______________________

I have examined the patient listed above and have cleared him/her for the purpose of purchasing hearing aid(s).

Comments:

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Physician Signature ______________________

Physician State License # ______________________