Certification of Disability

Applicant

First name _____ Last Name _____

The applicant requires certification of disability to be eligible for a free adapted telephone.

Please indicate the disability being certified.

☐ cognitive ☐ deaf ☐ deaf blind ☐ hard of hearing ☐ low vision/blind ☐ physical ☐ speech

Certifying Professional

I am a licensed audiologist

☐ licensed speech-language pathologist

☐ licensed physician

☐ representative of a qualified state agency

First name _____ Last Name _____ Title _____

Agency/ Organization _____ PA License # (if applicable) _____

Phone _____ Email _____

I certify that the applicant named above has the disability indicated, and that s/he requires technology to independently access telecommunications services.

Signature of Professional _____ Date _____