TECH OWL
TECHNOLOGY FOR OUR WHOLE LIVES

CERTIFICATION OF DISABILITY

Please print legibly or type. All information must be completed by a professional.

Applicant Name

(Last) _____ (First) _____ (MI) __

Please check one.

I am a(n):

- ☐ Audiologist
- ☐ Physician
- ☐ Speech-Language Pathologist
- ☐ Physician's Assistant
- ☐ Vocational Rehabilitation Counselor
- ☐ Registered Nurse Practitioner
- ☐ Optometrist
- ☐ Ophthalmologist
- ☐ Service Professional (public or private agency that serves deaf, hard of hearing and deafblind, Center for Independent Living employee, credentialed Assistive Technology Professional)

Please check the disability(ies) being certified:

- ☐ cognitive*
- ☐ deaf
- ☐ deafblind
- ☐ hard of hearing
- ☐ low vision
- ☐ blind
- ☐ physical*
- ☐ speech

*If you marked cognitive or physical disability, please explain why the applicant needs a specialized phone and/or wireless device. _____

_____

Certifying Professional

Full Name _____ Title _____

Agency _____

PA Professional License Number, if applicable _____

Phone _____ Fax _____

Email _____

I certify that the applicant named above has the disability indicated, and that they require this technology to independently access telecommunication services.

Signature of Certifier _____ Date _____

RETURN TO: TDDP@temple.edu OR FAX: 215-204-6336