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