

Certification of Disability

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Please print legibly or type. All information must be completed by a professional. (Return to: TDDP@temple.edu OR fax: 215-204-6336)

Applicant Name

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

Please check one. I am a(n):

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

Please check the disability(ies) being certified:

- | | |
|-------------------------------------|--|
| <input type="checkbox"/> cognitive* | <input type="checkbox"/> low vision |
| <input type="checkbox"/> deaf | <input type="checkbox"/> hard of hearing |
| <input type="checkbox"/> blind | <input type="checkbox"/> physical* |
| <input type="checkbox"/> deafblind | <input type="checkbox"/> speech |

*If you marked cognitive or physical disability, please explain why the applicant needs a specialized phone and/or wireless device and /or identify accessibility features that can be helpful (i.e. voice access for limited dexterity, photo labeled memory buttons for impaired cognition) _____

Certifying Professional

Full Name _____

Title _____ Agency _____

PA Professional License Number, if applicable _____

Area Code/Tel _____ 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 _____