Professional Certification Form

To get the ClearCaptions caption service at NO COST to you, have your Healthcare Professional complete and sign this simple form.

Completed and signed forms can be faxed to **877-846-9122**, scanned and emailed to **pcf@clearcaptions.com**, or mailed directly to:

ClearCaptions, LLC
ATTN: Certification
3010 Lava Ridge Court, Suite 200
Roseville, CA 95661

Individual with hearing loss (please complete all fields)		
First Name:	Last Name:	
Street Address:		
City:	State:	ZIP:
Phone:		
Email:		
Certifying Healthcare Professional (or Designee – check appropriate designation below)		
Professional's First Name:	Last Name:	
Professional Title:		
Business/Practice Name:		
Street Address:		
City:	State:	ZIP:
Phone:		
Email:		

Please check one:

- ☐ Audiologist
- ☐ Ear, Nose & Throat
- ☐ General Practice / Family Physician
- ☐ Physician Assistant
- ☐ Nurse Practitioner
- ☐ Hearing Instrument Specialist
- ☐ Geriatrician
- ☐ Pediatrician
- ☐ Other: _____

Certification:

- I certify that I have determined the individual referenced here has a form of hearing loss that makes it difficult to communicate effectively by telephone, requiring use of a caption telephone service to communicate in a manner that is functionally equivalent to a fully hearing person.
- I acknowledge that I understand that the captioning service is provided by a live Communications Assistant and that this service is funded through a federal program for the hearing impaired.
- I certify that I do not have any business, family or social relationship with any employee of ClearCaptions.
- I certify the above and, under penalty of perjury, that I am a hearing care or healthcare professional qualified to diagnose (or confirm the diagnosis of a professional for whom I am designee) of hearing loss.

Provider/Designee Name (Print) _____ **Signature** _____ **Date** _____