CaptionCall®
Life is Calling

Professional Certification Form

Instructions:

Please use this certification form to certify that the qualified patient listed below has hearing loss and requires the CaptionCall service to use the telephone in a manner that is functionally equivalent to a fully hearing person.

Please fax the completed form to 1-888-531-1906, or email it to certification@captioncall.com, or mail it to CaptionCall Certification, 4215 South Riverboat Rd., Salt Lake City, UT 84123. For assistance or questions, call 1-877-557-2227. Once the form is submitted, a CaptionCall representative will contact the individual with hearing loss to schedule installation of the phone.

Patient Information

Patient's Name: _____

Street Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ Email: _____

Preferred Caption Language: ▣ English ☐ Spanish **Desired product(s):** ☐ Home phone ☐ iPad app

Healthcare Provider Information

Business/Practice Name: _____ Promo Code: _____

Street Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ Email: _____

The following professionals may certify hearing loss (check applicable profession):

▣ Audiologist (AuD) ☐ Ear, Nose and Throat (ENT) ☐ Family Physician ☐ General Practice
☐ Geriatrician ☐ Gerontologist ☐ Hearing Instrument Specialist (HIS) ☐ Internal Medicine
☐ Otolaryngologist ☐ Pediatrician ☐ Nurse Practitioner (NP) ☐ Physician Assistant (PA)

Certification

- I certify, under penalty of perjury, that I am a hearing-care or healthcare professional and am qualified to diagnose hearing loss.
- I certify that I have determined that the patient referenced above has a hearing loss that makes it difficult to communicate effectively by telephone, and requires the use of captioned telephone service to communicate by telephone in a manner that is functionally equivalent to a fully hearing person.
- I certify that both I and the patient 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 Sorenson Communications or CaptionCall.
- I certify that the patient referenced above has explicitly authorized me to request that CaptionCall contact him or her regarding CaptionCall captioning services using the contact information provided above.

Professional's Name: _____ Title: _____

Professional's Signature: _____ Date: _____

Updated January 2017. Please use this form and discard all previous versions.