MEDICAL WAIVER

I have been advised by a representative of FAIRMONT HEARING AID SERVICE that the Food and Drug Administration has determined that my best health interests would be served if I were to have a medical evaluation by a licensed physician (preferably one who specializes in diseases of the ear) prior to a hearing aid evaluation and/or purchase of a hearing aid.

I DO NOT WISH to be evaluated medically at this time for the reason indicated below:

- ☐ I am an experienced hearing aid wearer and I am purchasing a replacement aid(s).
- ☐ I see my personal physician annually and do not wish to return at this time.
- ☐ I have recently seen my physician and do not wish to request medical clearance at this time.
- ☐ Other: _____

Patient Name: _____ Date: ____/____/____
First Middle Last

Patient Signature: _____

(Office Use Only)

Hearing Professional Name: _____ Date: ____/____/____
First Middle Last

Hearing Professional Signature: _____

License Number: _____ State: _____