



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: _____

HEAR BETTER. LIVE BETTER.

125 1st St. NW
Le Mars, IA 51031
Phone: 712.546.4723

119 E. 5th St.
Spencer, IA 51301
Phone: 712.262.7774

400 N. State St.
Fairmont, MN 56031
Phone: 507.235.5323

1039 Oxford St.
Worthington, MN 56187
Phone: 507.376.4616