MIAMI-DADE COUNTY PUBLIC SCHOOLS
Division of Special Education
Deaf and Hard of Hearing Program

Print Student's Name (Last)	(First)	(M.I.)	DATE (MM/DD/YY)
			STUDENT ID. NO.

MEDICAL CLEARANCE FOR AMPLIFICATION

Physician's Statement:

This student is cleared for use of hearing aid(s) and/or other Assistive Listening Devices.

Physician's Signature **Date**

Physician's Name *(Printed)* **Physician's License or Certificate No./Issuing State**

Address

Phone and Fax Numbers

Please Return Completed Form To:

Miami-Dade County Public Schools

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For M-DCPS Use Only			
School	**Date Received**	**Region**	**Audiologist**