HEAR CLEARLY
Dr. Susan Antonellis
1025 Northern Blvd. Suite 304 Roslyn, NY 11576
516-690-0202 office ~ 516-304-5995 fax

Medical Clearance Form

(Please have your doctor complete and sign this form)

Patient's Name: ______________________________ Date of Birth: ______________

Address: ______________________________ Phone #: (   )______________

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1. Brief summary of ENT Findings: ______________________________
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2. Are there any contraindications to the use of a hearing aid or ear mold?

   Yes_____ If yes, please explain: ______________________________

   No_____ if no, may the patient purchase and wear a hearing aid if indicated? Yes _____

3. Additional comments: ______________________________
____

Doctor's Signature: ______________________________

Date: ______________________________

Print Doctor's Name: ______________________________

Address: ______________________________

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Phone Number: ______________________________