RELEASE OF INFORMATION
FOR VERIFICATION OF HEARING LOSS

The student completes the following:

I, _____, herby authorize the release of the following information as well as any pertinent documentation to the Student Accessibility Services at Florida Atlantic University for the purpose of determining my eligibility for academic accommodations.

Student's Signature _____ Phone: _____

Student's Z# _____ Date of Birth: _____

☐ Please return paperwork to client/student.

☐ Please return the completed information to the campus checked below:

☐ Florida Atlantic University
Student Accessibility Services
777 Glades Road, SU 133
Boca Raton, FL 33431
tel: 561.297.3880 fax: 561.297.2184

☐ Florida Atlantic University
Student Accessibility Services
3200 College Avenue, LA 131
Davie, FL 33314
tel: 954.236.1222 fax: 954.236.1123

☐ Florida Atlantic University
Student Accessibility Services
5353 Parkside Drive, SR 111F
Jupiter, FL 33458
tel: 561.799.8585 fax: 561.799.8819

VERIFICATION OF HEARING LOSS

(To be completed by qualified diagnostician)

Patient's Name: _____ Date of Most Recent Examination: _____

1. Diagnosis: Right Ear _____ Left Ear _____
2. Etiology: Right Ear _____ Left Ear _____
3. Prognosis: Permanent ☐ Temporary ☐ How long? _____
4. Degree of Hearing Loss: Right Ear _____ Left Ear _____
5. Type of Hearing Loss: Right Ear _____ Left Ear _____
6. Use of Hearing Aid: Right Ear _____ Left Ear _____

****Please attach an audiogram along with a written narrative defining the hearing loss.**

7. Is the student on any medication that may affect attention, concentration, or any other facet of learning or living environment? Yes ____ No ____

   Medication: _____

   Medication: _____

   Side Effects: _____

8. Describe in detail the student's functional limitations associated with this diagnosis. How might this disability impact the student academically?

   _____

   _____

   _____

9. Are there any specific academic accommodations you would recommend for this student?

   _____

   _____

   _____

Please attach any additional documentation which you feel may help us determine the most appropriate assistance for this student.

CLINICAN'S NAME (Printed) _____

CLINICIAN'S SIGNATURE_____ DATE_____

CREDENTIALS_____

LICENSE/CERT. # _____ STATE_____

Please attach your business card (if available)