Alaska Relay Telecommunications Equipment and Tablet Distribution Program

Professional Certification Form

AGR # _____

Applicant's Full Name: _____

Phone: _____ ☐ Text ☐ Voice ☐ Videophone

This certification was completed by one of the following:

- ☐ Licensed Physician
- ☐ Certified Audiologist or Hearing-Aid Specialist
- ☐ Certified Speech-Language Pathologist
- ☐ Division of Vocational Rehabilitation
- ☐ Department of Education

It is my professional opinion that the applicant has a hearing or speech impairment which causes a barrier to access distance communication.

Agency: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Name of Certifier: _____

Signature: _____ **Date:** _____

An examination or records show that the applicant has one or more of the following disabilities which causes an impediment to access the telephone system:

- ☐ Deaf
- ☐ Severe Hearing Loss*
- ☐ Severe Speech Disabiltiy

**Individuals considered "Severe Hearing Loss" must have a hearing loss of 30Db average in the frequencies <500,1000 &2000> or greater in the better ear. If the audiogram is available, please provide a copy.*

PLEASE COMPLETE AND RETURN THIS FORM TO:
ATLA - Assistive Technology of Alaska
1500 W 33rd Ave, Ste 120
Anchorage, AK 99503

TOLL - FREE: 1 (800) 723 - 2852
VOICE: 1 (907) 563 - 2599
VIDEO: 1 (907) 312 - 5901
FAX: 1 (907) 563 - 0699
EMAIL: akrelay@atlaak.org