Alaska Relay Telecommunications Equipment and Tablet Distribution Program

Professional Certification Form

AGR # ______________

Applicant's Full Name: ______________________________

Phone: ______________________ ☐ Text ☐ Voice ☐ Videophone

The remainder of this form must be completed by the certifier.

Agency: ______________________________

Address: ______________________________

City: ______________ **State:** ______ **Zip:** ______________

Please identify your job title from one of the following:

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

Other entites may complete this certification upon approval.

In your professional opinion, does the applicant identified above have a hearing or speech impairment which causes a barrier to access distance communication? If so, please identify the applicant's area of need:

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

**Individuals considered "Severe Hearing Loss" must have a hearing loss of 30bD average in the frequencies <500,1000 &2000> or greater in the better ear.*

Signature: ______________________________ **Date:** ______________

Printed Name: ______________________________

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

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