# 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 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

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 need:

☐ Deaf
☐ Severe Hearing Loss*
☐ Severe Speech Disability

**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.*

**Signature:** _____ **Date:** _____

**Printed Name:** _____

**PROGRAM ADMINISTRATION WHO PROVIDES EQUIPMENT:**
ATLA - Assistive Technology of Alaska
1500 W 33rd Ave., STE 120
Anchorage, AK 99503

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