



Alaska Relay Telecommunications Equipment and Tablet Distribution Program

Professional Certification Form

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
- Hard of Hearing
- Severe Speech Disability

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