



## Deaf/Hard-of-Hearing Documentation Form

**Student Name:** \_\_\_\_\_ **DOB:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_ has requested support services from Accessible Educational Services (AES) at Indiana University Bloomington (IUB) regarding a hearing impairment. Documentation provides vital information about the functional limitation of the student's a qualifying medical condition and its impact in a post-secondary academic environment.

Please complete all sections of this form and return it as soon as possible so that we may verify the student's eligibility for services. Providers may also use their own format if the information requested below is included; if this information is not provided, services may be delayed as AES obtains clarification. Please call 812-855-7578 if you have questions. The completed form may be faxed to 812-855-7650 or it may be mailed to the address at the bottom of this page. AES welcomes any additional documentation you would like to include.

**Diagnoses**

Primary: \_\_\_\_\_

Secondary: \_\_\_\_\_

Date of Diagnosis: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Last appointment: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Type and Severity of Hearing Loss:** Please attach the latest audiological assessment and copy of the audiogram.

**Right Ear:** \_\_\_\_\_

**Left Ear:** \_\_\_\_\_

**Characteristics of hearing loss:**  Stable  Declining  Slow Progression  Rapid Progression

**Recommended time-frame for audiological update:** \_\_\_\_\_

**Assistive or Adaptive Technology:**

**Are hearing aids, FM systems, cochlear implant(s) or other devices prescribed to assist the student's hearing? If so, indicate which type of device(s) and the student's hearing threshold when using the device (s).**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



**If the student currently uses assistive or adaptive technologies related to his or her hearing impairment, please list specifics about the technology. If the student needs an FM system or other hearing device in the classroom, what FM system or recommended hearing device would be compatible?**

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**Please explain how the student will be affected in the following academic settings (REQUIRED):**

Lecture: \_\_\_\_\_

Small group discussion: \_\_\_\_\_

Movies and other audio media: \_\_\_\_\_

**Additional comments and recommended auxiliary support, strategies, or service that may be beneficial to the student in the higher education environment.**

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**Certifying Professional**

**Name (*print*):** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Profession:** \_\_\_\_\_ **License number:** \_\_\_\_\_

**Office Address:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_ **Email Address:** \_\_\_\_\_

**Certifying Professional Signature:** \_\_\_\_\_