Children's Mercy HOSPITALS & CLINICS

Hearing Aid Loss/Damage Form

7093-063 MR 07/10

PARENT OR GUARDIAN:

Complete and return this form to the Hearing and Speech Clinic. If you have questions, please contact the Hearing and Speech department at (816) 234-3677.

Fax: (816) 234-3291 **Mailing Address: 2401 Gillham Road**
Kansas City, Missouri 64108

Patient Name: _____

Phone Number: (_____) _____-_____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Hearing Aid Information

Make/Model: _____

Serial Number(s): _____

Date of Purchase: _____/_____/_____

Date of Loss or Damage: _____/_____/_____

Explanation of Loss or Damage: _____

_____

_____

_____

_____

_____ _____
Signature of Person Completing This Form Printed Name of Person Completing This Form

_____ _____/_____/_____
Relationship to Patient Date

In witness whereof I have hereunto subscribed my name and affixed my official seal this _____ day of _____, 20_____.

_____
Notary Public

My Commission Expires: _____/_____/_____

STAFF USE ONLY:

Hearing Aid Company: _____

Account Number: _____

I have reviewed the information provided above. Please replace the above hearing aid according to the loss and damage warranty.

Audiologist (Name): _____

Signature: _____ Date: _____/_____/_____ Time: _____ hours