City of Vancouver Human Resources
415 W 6th St – 3rd Floor/P.O. Box 1995
Vancouver, WA 98668-1995
P: 360.487.8403 F: 360.487.8418
Email: April.Stinson@cityofvancouver.us

Hearing Aid Application Request

(To Be Completed by Member, Family Member or Legal Rep – please check one)

☐ Member ☐ Family Member ☐ Legal Rep ☐ Other: _____

Name:	SSN:	Telephone Number:
Complete address including zip code:	Pension Board: ☐ Police ☐ Fire	Medical Insurance: ☐ Kaiser Permanente ☐ Regence ☐ Other _____

ADDITIONAL INFORMATION

What recent conditions or events have occurred causing you to consider a change in your circumstance? Please be specific.

I hereby certify, under the penalty of perjury in the State of Washington, that this application contains no willful misrepresentation, and that the information is true and complete to the best of my knowledge and belief.

Signature: _____ Date: _____

Print Name: _____ Relationship to Member: _____

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Physician's Statement

LEOFF I Member Name:	SSN:	Birth Date:

*The LEOFF I member, as listed above, has applied to the City of Vancouver Pension Board for approval of medical services. Please complete and sign the **PHYSICIAN** section of the form as listed below.*

Hearing Test Conducted (please check all that apply):

☐ Pure-tone ☐ Bone conduction ☐ Speech ☐ Auditory brainstem response (ABR)

☐ Otoacoustic emissions test (OAE) ☐ Impedance testing (tympanometry and acoustic reflexes)

Severity of Hearing Loss:	Left	Right
Slight Hearing Loss (16 - 25db)	☐	☐
Mild Hearing Loss (26 - 40db)	☐	☐
Moderate Hearing Loss (41 – 55db)	☐	☐
Moderately Severe Hearing Loss (56 – 70db)	☐	☐
Severe Hearing Loss (71 – 90db)	☐	☐
Profound Hearing Loss (91+db)	☐	☐

Type of Hearing Loss (please check one):

☐ Sensorineural ☐ Conductive ☐ Mixed ☐ Other: _____

Additional Information (please circle all that apply):

Bilateral	Unilateral
Symmetrical	Asymmetrical
Progressive	Sudden Onset
Fluctuating	Stable

Diagnosis:	Prognosis:
Based on the needs of the patient, I would recommend the following (please be specific):	

PROVIDER INFORMATION

Type of Provider (please check one):

☐ Audiologist ☐ Hearing Instrument Specialist ☐ Other:_____

Physician's Signature: _____ Date: _____

Typed or Printed Name_____ Phone: _____

Physical Address, including zip code:	Mailing Address, including zip code:

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