

Third Party Certification of Eligibility for IP CapTel Service



INSTRUCTIONS

In order to receive a CapTel IP-based telephone at no charge, applicants must obtain independent third-party certification of their hearing loss and their need to use IP-based CapTel service in order to be able to communicate over the telephone in a functionally equivalent manner.

This certification must be signed by a third-party professional who is qualified to evaluate an individual's hearing loss in accordance with applicable professional standards, and must be either a physician, audiologist, or other hearing related professional.

Please have a third-party professional, as described above, complete this form or provide a statement on his or her letterhead that includes the same information, then submit your certification to CapTel, Inc.

Send to:

- By Email:** Register@CapTel.com
- By Fax:** (608) 238-3008
- By Mail:** CapTel, Inc.
450 Science Drive
Madison, Wisconsin 53711

Questions?

Contact Registration Help at 1-877-202-9578 or email to Register@CapTel.com.

- I do not have a phone already, please ship to my address.**
- I received a phone from OEI rep.**
Date Received: _____
Crystal Vaccaro, Outreach Expert
720-481-7188
Crystal.Vaccaro@outreachexpertsinc.com

Internal Use Only: H/S

This certification applies to IP-CTS (Internet-based) CapTel models only. Not applicable for CapTel models that do not require an Internet connection.

Per FCC requirements: to use the free captioning service, IP-CTS users must register - including providing name, contact information, birthdate, and the last four digits of their social security number - before captions feature can be activated. Per FCC regulations, all user information is kept confidential.

Customer's Information *(Please print)*

Name: _____

Address: _____ Apt # _____

Telephone Number: _____

Email: _____

CapTel Model: *(circle one)* 800i 840i 880i 2400i

CapTel Serial Number/ESN (if available):

(located on bottom of CapTel)

Certifying Professional *(Please print)*

Name: _____

Title: _____

Physician Hearing Related Professional

Audiologist _____ *(please specify)*

Address: _____

Telephone Number: _____

Email: _____

Under penalty of perjury, I certify that, in my professional opinion, the IP-CTS User is an individual with hearing loss that necessitates use of captioned telephone service. I understand that the captioning on captioned telephone service is provided by a live communications assistant and is funded through a federal program.

I have not been referred to the IP-CTS User, either directly or indirectly, by any provider of TRS or any officer, director, partner, employee, agent, subcontractor, or sponsoring organization or entity (collectively "affiliate") of any TRS provider. I do not have a business, family, or social relationship with the TRS provider or any affiliate of the TRS provider.

Signature _____

Date _____