

Gift of Hearing Nomination Form

Nominee Name: _____ Age: _____
City of Residence: _____
Does nominee currently wear hearing aids? Yes _____ No _____
If yes, how many hearing aids? One _____ Two _____
Occupation: _____

Please explain why you believe your nominee should receive the “Gift of Hearing” from DeFatta Hearing Aid Experts. You may use a separate sheet of paper if necessary.

Your name/Relationship to nominee: _____
Daytime Phone: _____ Email Address: _____

We may contact you if we need additional information. The recipient will be chosen at the sole discretion of DeFatta Hearing Aid Experts and based on the following criteria: hearing need, financial need, opportunity to impact recipient’s life, and opportunity to impact the lives of people with whom they interact. The recipient must be able to travel to our office for appointments (hearing evaluation and hearing aid fitting). In accordance with FDA regulations, the recipient will be required to obtain a medical referral for a hearing test prior to being fit with hearing aids, as well as medical clearance to be fit with hearing aids.

You may return this form via email at: hearing@defattaent.com, fax: (715) 839-7786, in-person, or mail to our Altoona office: 1490 Rivers Edge Trail Altoona, WI 54720.

Thank you for taking part in our Gift of Hearing nominations!



HEARING AID EXPERTS