Third Party Certification of Eligibility for IP CapTel Service

CapTel® Captioned Telephone

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, or by an authorized representative from a local, state or federal government program.

Please have a third party professional as described above complete this form, then submit to:

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

Code: NHWEB

__ **I do not have a phone already.**

__ **I received a phone from OEI rep.**
Date Received: _____

Rep Name: _____

Internal Use Only: 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 (if known): *(circle one)*
840i 880i 2400i

CapTel Serial Number/ESN (if known):

_____
(located on bottom of CapTel)

Certifying Professional *(Please print)*

Name: _____

Title: _____

Business Name: _____

☐ **Physician** ☐ **Hearing Related Professional**

☐ **Audiologist** _____ *(please specify)*

☐ **Government Program** _____ *(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 _____