van Asch Deaf Education Centre
38 Truro Street, Sumner
Christchurch 8081
Ph/TTY (03) 326 6009

Hearing Aid Repair Request

*(Please fill in **ALL** details)*

Date: ________________ Sender's Name: ______________________________

Sender's Contact Ph. / email: ______________________________

Hearing Aid Wearer's First Name: _______________________

Hearing Aid Wearer's Last Name: _______________________

Hearing Aid Wearer's D.O.B. __________

IMPORTANT - Please indicate if the student has been diagnosed with APD (Auditory Processing Disorder) Yes ☐ No ☐

Home Address: ____

____

____

Audiology Clinic: ____

Address where Hearing Aid is to be returned: _________________________

____

____

Make _______________ Model ______________ Serial No. ________________

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FAULT *(Please describe problem in full)*

If unrepairable please name who is to be contacted and supply contact details - ____

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