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)

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(Please fill in ALL details)

Date:	Sender's Na	me:	Date:	Sender's Na	me:
Sender's Conta	act Ph. / email:		Sender's Contact Ph. / email:		
Hearing Aid W	earer's First Name:		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		
Hearing Aid W	earer's Last Name:				
Hearing Aid W	earer's D.O.B				
_	Please indicate if the s APD (Auditory Proces				
Home Address:			Home Address:		
Audioloay Clin	ic:		Audiology Clin		
Address where Hearing Aid is to be returned:			Address where Hearing Aid is to be returned:		
	Model	Serial No	 Make	Model	Serial No.
		Serial No			Serial No.
Make	Model	Serial No			Serial No
Make	Model	Serial No	Make	Model	Serial No
FAULT (Please describe problem in full)			FAULT (Please describe problem in full)		
If unrepairable please name who is to be contacted and supply contact details -			If unrepairable please name who is to be contacted and supply contact details -		