



District 75 - Citywide Programs
400 First Avenue
New York, NY 10010



MEDICAL CLEARANCE FOR AN FM UNIT

NAME: _____

DATE OF BIRTH: _____

OSIS: _____

This is to indicate that there are no medical contraindications to the above named child's use of a personal FM unit.

PHYSICIAN NAME: _____

PHYSICIAN SIGNATURE: _____

This form can be accepted only when signed by an M.D.

ADDRESS: _____

PHONE: _____

LICENSE NUMBER: _____

DATE: _____

Please return this form to the School Psychologist or to the CSE Audiologist

Thank you.