Florida Telecommunications Relay, Inc. (FTRI) Application

Section 1- All information must be completed with original signatures. No copies/faxes.

How Did You Hear About This Program?
(Circle One)

(1) Friend/Family (2) Physician (3) Hearing Aid Specialist
(4) Audiologist (5) FTRI Presentation (6) Television
(7) Newspaper (8) FTRI Website (9) Other____________

Social Security Number ________________________________

First ______________________ Middle ________________ Last ________________________

Birth Date ______________ Home Phone ( ) ________________ Day Phone ( ) ________________
(No Cell #)

Phone Carrier ❑ AT&T ❑ Verizon ❑ Comcast ❑ Century Link ❑ Other ______________________

Address ________________________________ (Apt) __________ City ______________________

FL Zip Code ____________ County ____________ Email ____________________________________ FL

Shipping Address (if different): ____

City ____ FL Zip Code ______________

Alternate contact person ______________________ Relationship ______________ Phone ( ) ______________

By signing this I certify that I am a permanent Florida resident who has a hearing loss and/or speech impairment, that **I understand and accept the conditions of acceptance,** and that the information I have given is true. I authorize the certifier of this application to provide this information to FTRI in order that I can receive the designated specialized telecommunications equipment.

Signature of Applicant X ______________________ Date __________ Print Name ______________________
(If under 18, Parent or Guardian / POA must provide documentation)

Section 2- to be completed by the certifier

In accordance with Chapter 427.705 F.S., I am eligible to certify FTRI applications. I am:

❑ Deaf Service Center Director
❑ Speech Pathologist
❑ Hearing Aid Specialist
❑ Appropriate State or Federal agency representative
❑ Audiologist
❑ State Certified Teacher for the Hearing or Visually Impaired
❑ Licensed Physician

Application must be certified within the State of Florida. I certify that the applicant is: *(check one)*

❑ **Hard of Hearing.** Having a permanent hearing impairment which is severe enough to necessitate the use of amplification devices to discriminate speech sounds in verbal communication.

❑ **Deaf.** Having a permanent hearing impairment and being unable to discriminate speech sounds in verbal communication with or without the assistance of amplification devices.

❑ **Speech Impaired or having a speech impairment.** Having a permanent loss of verbal communication ability which prohibits normal usage of a standard telephone handset.

❑ **Dual sensory impaired.** Having both a permanent hearing impairment and a permanent visual impairment, and includes deaf/blindness.

Certifier's Name (Print) ______________________________ State License # ______________________

Agency Name ______________________________ County ______________________

Address ______________________________ City ______________ State ______ Zip __________

Telephone Number ( ) ______________________ Certifier's Signature X ______________________

Certifier information must be complete to process application. For questions please call 1-800-222-3448.
This application will not be returned to you. If you would like a copy, please make one before sending in.

EDP ID#:____________ (Where client received phone) **SERVICE PROVIDER ID #:**____________ **OUTREACH EVENT ID #:**____________