

## Hearing Aid Recycling Programme Application Form

PERSONAL PARTICULARS			
Name (Mr/Ms/Mrs/Mdm/Dr/Rev)			
NRIC No.		Date of Birth	
Address	Postal Code (            )		
Email Address			Nationality
Home Tel No.	Fax No.	Handphone No.	
Occupation			Gender Male / Female
Company's Name & Address			Company Tel / Fax / Email
Race	Chinese / Malay / Indian / Eurasian / Others _____		
Marital Status	Single / Married / Separated / Divorced / Widowed		
Education Level	None/Kindergarten/PSLE/GCE 'N'/GCE 'O'/GCE 'A'/Certificate/Diploma/Degree/Others _____		
Sign System	#SEE / ASL / NSL / PSE / Shanghainese / Gesturing / Others _____		
Speech (Yes/No)	If yes , please state Language/Dialect _____		
Onset of deafness	Year _____	Cause	
Hearing Profile	<input type="checkbox"/> Oral or Signing <input type="checkbox"/> Congenital or Late Loss <input type="checkbox"/> Moderate <input type="checkbox"/> Severe or Profound		
Left Ear	mild / moderate / severe / profound / normal	Right Ear	mild / moderate / severe / profound / normal
Salary (per month)	<input type="checkbox"/> Less than \$200 <input type="checkbox"/> Over \$1000 to \$1500 <input type="checkbox"/> Over \$2500 to \$3000 <input type="checkbox"/> \$200 to \$500 <input type="checkbox"/> Over \$1500 to \$2000 <input type="checkbox"/> Over \$3000 to \$3500 <input type="checkbox"/> Over \$500 to \$1000 <input type="checkbox"/> Over \$2000 to \$2500 <input type="checkbox"/> Over \$3500		
Type of Housing	<input type="checkbox"/> 1 room HDB Flat <input type="checkbox"/> 4 room HDB Flat <input type="checkbox"/> Condominium / Private Housing <input type="checkbox"/> 2 room HDB Flat <input type="checkbox"/> 5 room HDB Flat <input type="checkbox"/> 3 room HDB Flat <input type="checkbox"/> Executive Flat		
I hereby certify that the above information furnished by me is correct at the point of application.			
			_____ Signature / Date

**FOR OFFICIAL USE ONLY**

<b>Recommendation by Referring Agency/ Social Worker</b>	
_____ Name of Administrator / Social Worker	_____ Signature / Date
<b>Recommendation by SAdeaf Social Worker</b>	
Eligibility Category:	<u>Remarks</u>
<input type="checkbox"/> Exhausted ATF Fund <input type="checkbox"/> Needy, but not eligible for ATF <input type="checkbox"/> Subsidized Patient in Senior Citizens' Home <input type="checkbox"/> Needy Elderly	
_____ Name of Social Worker	_____ Signature / Date
<b>Attended by:</b>	
_____ Name of Fitting Audiologist	_____ Signature / Date