

# Third Party Certification of Eligibility for IP CapTel Service



## INSTRUCTIONS

In order to receive a CapTel IP-based telephone at no charge, applicants must obtain independent third-party certification of their hearing loss and their need to use IP-based CapTel service in order to be able to communicate over the telephone in a functionally equivalent manner.

This certification must be signed by a third-party professional who is qualified to evaluate an individual's hearing loss in accordance with applicable professional standards, and must be either a physician, audiologist, or other hearing related professional, or by an authorized representative from a local, state or federal government program.

Please have a third party professional as described above complete this form, then submit to:

### Send to:

**By Email:** Register@CapTel.com

**By Fax:** (608) 238-3008

**By Mail:** CapTel, Inc.  
450 Science Drive  
Madison, Wisconsin 53711

### INTERNET

#### Questions?

Contact Registration Help at 1-877-202-9578

- I do not have a phone already.
- I received a phone from OEI rep.  
**Date received:** \_\_\_\_\_  
**Rep Name:** \_\_\_\_\_

Internal Use Only: H/S

This certification applies to IP-CTS (Internet-based) CapTel models only. Not applicable for CapTel models that do not require an Internet connection.

**Per FCC requirements:** to use the free captioning service, IP-CTS users must register - including providing name, contact information, birthdate, and the last four digits of their social security number - before captions feature can be activated. Per FCC regulations, all user information is kept confidential.

## Customer's Information *(Please print)*

**Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Apt #** \_\_\_\_\_

*City State Zip*

**Telephone Number:** \_\_\_\_\_

**Email:** \_\_\_\_\_

**CapTel Model (if known):** *(circle one)*  
840i 880i 2400i

**CapTel Serial Number/ESN (if known):**

*(located on bottom of CapTel)*

## Certifying Professional *(Please print)*

**Name:** \_\_\_\_\_

**Title:** \_\_\_\_\_

**Business Name:** \_\_\_\_\_

Physician  Hearing Related Professional

Audiologist \_\_\_\_\_  
*(please specify)*

Gov. Program or VSO \_\_\_\_\_  
*(please specify)*

**Address:** \_\_\_\_\_

**Telephone Number:** \_\_\_\_\_

**Email:** \_\_\_\_\_

Under penalty of perjury, I certify that, in my professional opinion, the IP-CTS User is an individual with hearing loss that necessitates use of captioned telephone service. I understand that the captioning on captioned telephone service is provided by a live communications assistant and is funded through a federal program.

I have not been referred to the IP-CTS User, either directly or indirectly, by any provider of TRS or any officer, director, partner, employee, agent, subcontractor, or sponsoring organization or entity (collectively "affiliate") of any TRS provider. I do not have a business, family, or social relationship with the TRS provider or any affiliate of the TRS provider.

**Signature** \_\_\_\_\_

**Date** \_\_\_\_\_