

**Virginia Department of Health  
Division of Child and Adolescent Health  
Virginia Early Hearing Detection and Intervention Program**

**VIRGINIA HEARING AID LOAN BANK  
LOAN EXTENSION APPLICATION FORM**

**Please complete this application and return to:**

Lisa Powley  
C/o Blue Ridge Care Connection for Children  
P. O. Box 800421  
Charlottesville, VA 22908  
Phone: (434) 924-0222 Fax: (434) 924-0390  
Toll free: 866-596-9367

**The information contained on this form will be kept confidential.**

**PART A – To be completed by the referring audiologist**

Audiologist Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
\_\_\_\_\_

Phone Number: \_\_\_\_\_

Child's Name and Date of Birth: \_\_\_\_\_

Parent/Legal Guardian's Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
\_\_\_\_\_

Phone Number: \_\_\_\_\_

Date child fit with loaner aid or FM system: \_\_\_\_\_

\_\_\_\_\_  
Audiologist Signature

\_\_\_\_\_  
Date

**Virginia Hearing Aid Loan Bank  
Extension Agreement**

**PART B – To be completed by the parent or legal guardian**

1. Please describe why you need the hearing aid(s) or FM system(s) for three more months.

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2. When will your child get permanent hearing aid(s) or FM system?

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Signature of Parent /Legal Guardian

\_\_\_\_\_  
Date