Apply today. It's fast, easy, and no cost to you!

1. Complete this section. There is no obligation.

Last Name _____ First Name _____ MI _____

Street Address _____ City _____ State CA Zip _____

Your Telephone Number* (____) _____

Email Address (optional) _____

*Cannot be a cellular phone.

Alternate Contact (First & Last) _____

Relationship _____ Tel. Number (____) _____

Your Local Phone Company's Name _____

Name on Phone Bill (First & Last)* _____

Ethnicity (optional): ☐ Caucasian ☐ Latino ☐ African American ☐ Native American ☐ Pacific Islander ☐ Asian ☐ Other

Age: ☐ 18 or under ☐ 19–35 ☐ 36–55 ☐ 56–75 ☐ Over 75

IMPORTANT, READ BEFORE SIGNING Limited Liability Agreement. The applicant hereby agrees that the CPUC and/or the State of California and/or the California Communications Access Foundation (CCAF) make(s) no warranties, either express or implied, with regard to the possession, use, condition, and/or operation of the telecommunications equipment provided to applicant as part of this program (the Equipment). The applicant hereby agrees to indemnify, defend, and hold harmless the CPUC, the State of California, and/or the CCAF from any and all third party claims, costs (including without limitation reasonable attorneys' fees), and losses which in any way arise out of or in connection with the possession, use, condition, and/or operation of the Equipment. The applicant hereby agrees that the CPUC, the State of California, and/or the CCAF shall have no liability to the applicant or any other person with respect to any liability, loss, or damage caused or alleged to be caused, directly or indirectly, by or through the possession, use, and/or operation of the Equipment. I verify that I live in a household that subscribes to local telephone service in California.

_____

Signature of Applicant Date

How did you hear about us:

Radio_____ Television_____ Newspaper_____ Phone book _____ Bus ☐ Event_____

2. Have this section completed by one of these certifying agents:

☐ CA State Licensed Medical Doctor ☐ CA Licensed Optometrist ☐ CA Licensed Audiologist ☐ CA Department of Rehabilitation Counselor
☐ CA Superintendent/Audiologist from the Fremont/Riverside School for the Deaf ☐ CA Licensed Hearing Aid Dispenser (see provision below)**

Impairment(s) of the Applicant: ☐ Deaf/Deafened ☐ Mobility/Manipulation ☐ Hard of Hearing ☐ Blind ☐ Low Vision ☐ Speech ☐ Cognitive Special Equipment/dB Recommended: _____

Hearing Loss: ☐ Mild ☐ Moderate ☐ Severe Mobility: ☐ Upper body ☐ Lower Body ☐ Both

I certify that the above named person has the impairment(s) marked above that restrict(s) his or her use of the telephone and qualifies for equipment provided under California state legislation.

Print Name (Must be legible) _____

Degree (MD, DO, OD, AuD, PhD, MS, MA, Other): _____ License Number _____

Telephone (____) _____ Fax (____) _____ Signature of Certifying Agent _____ Date _____

** For CA Licensed Hearing Aid Dispensers – I certify that I have fitted the above person with an amplified device and have the individual's hearing records on file.

_____ _____ (____) _____

Signature (Hearing Aid Dispensers only) Date CA HAD License Number Telephone

3. Submit your request by fax, mail, or in person. Already certified? No need to reapply!

By fax: 1-800-889-3974 **By mail:** CTAP P.O. Box 30310, Stockton, CA 95213

In person:

Burbank 303 N. Glenoaks Blvd., Suite L-130
Fresno 7525 N. Cedar Ave., Suite 115
Berkeley 3075 Adeline Street, Suite 260
Riverside 6370 Magnolia Ave., Suite 310
Sacramento 2033 Howe Ave., Suite 150
San Diego 2878 Camino Del Rio South, Suite 400
Santa Ana 2677 N. Main St., Suite 130

If submitted by fax or mail, we'll contact you. Preferred Language: _____ ☐ Braille ☐ Large Print

For further information or more certification forms:

English 1-800-806-1191 Español 1-800-949-5650 國語 1-866-324-8747
TTY 1-800-806-4474 Hmoob 1-866-880-3394 廣東話 1-866-324-8754 **www.ddtp.org**

English Download '08

California Telephone Access Program
A Program of the California Public Utilities Commission