REPAIR FORM

Name:_____ Date:_____

Date Symptoms Started:_____
In Other Words – When Did You First Begin To Have This Problem?

Check Following Symptom(s) Occurring to Aid

☐ **Right Ear**

☐ Dead
☐ Weak
☐ Distorted
☐ Intermittent On/Off
☐ Battery Door
☐ Other_____
_____
_____
_____

☐ Battery Drain
☐ Static
☐ Popping
☐ Feedback Or Whistling
☐ Hurting Ear

☐ **Left Ear**

☐ Dead
☐ Weak
☐ Distorted
☐ Intermittent On/Off
☐ Battery Door
☐ Other_____
_____
_____
_____

☐ Battery Drain
☐ Static
☐ Popping
☐ Feedback Or Whistling
☐ Hurting Ear

Signature_____ Date_____

Revised 6/04