**In-Home Talking Medical Device**

**Application Form**

**This project would not be possible without a generous grant from Aflac. The following information will be kept confidential. Once you have completed this application, please sign and mail it to the following address.**

**Federation Center of the Blind**

**TMD Project**

**119 S. Kilbourne Rd**

**Columbia, SC 29205.**

**Completed signed applications can also be emailed to the Federation Center at** **nfbsc@sc.rr.com****.**

**Please provide a written statement from your doctor on business letterhead verifying your need for the specified talking in-home medical device. Please be as specific as possible. Only ONE device will be considered for each applicant at this time. No applications will be considered until a doctor’s statement is also received.**

**Once the application and doctor’s statement are received, the Talking Medical Device Review Committee will review the applications and notify the individual of the determination. The TMD Review Committee will meet biweekly, but will adjust the meeting frequency as determined by the applications received.**

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

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

**City, State, ZIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone #1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone #2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Are you legally blind?**

**\_\_\_ Yes \_\_\_ No**

**Health condition you need to track:**

**\_\_\_ Blood Sugar \_\_\_ Blood Pressure**

**\_\_\_ Weight control \_\_\_ Daily Walking/number of steps**

**\_\_\_ Body Temperature \_\_\_ Oxygen level**

**\_\_ Other and describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please explain, in your own words, the reason you need a talking in home medical device:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Signature Date**