DEPARTMENT OF STATE HEALTH SERVICES
AUDIOMETER LOAN APPLICATION

1. **Name of Organization**	6. **Name of Person Requesting Loan**
2. **Organization Mailing Address**	7. **Physical Location:** *(Shipping address)* ***Do Not Use P.O. Box #***
3. **County:**	8. **Number of People to be Screened:**
4. **First Choice for Screening:** *(Start and End Date)*	9. **Facility Phone Number:** *(Including Area Code)*
5. **Second Choice for Screening:** *(Start and End Date)*	10. **Screener's Phone Number:** *(Including Area Code)*

11. **Name of *ALL PERSONS* who will be using the Equipment:**

NAME	**NAME**

Should more than six persons be using the equipment, please attach a separate sheet with names and numbers.

*If this application is approved, I will **assume responsibility** for this State owned equipment.*
***I agree to return it on the date** indicated in my loan agreement - **insured,** at my own expense.*

*I affirm that all hearing screening performed with this equipment will be **at no cost to the individuals screened.***

Signature of person borrowing the equipment _____ Date _____

FOR OFFICE USE ONLY BELOW THIS LINE

Approved Loan Period:	
Inventory Number:	**Date Due Calibration:**
Manufacturer:	**Model:**
Value:	**Date of Shipment/Pick-Up:**

DEPARTMENT OF STATE HEALTH SERVICES
AUDIOMETER LOAN APPLICATION

We have a limited number of audiometers for short-term loans to schools, day care centers and other organizations that need this equipment to screen for hearing problems. There is no charge for this service other than the one-way freight and insurance costs to return the equipment to this department.

Persons who use this equipment must be registered with this agency as an ***Audiometer User.*** They must affirm that all hearing screening performed with this equipment will be at no cost to the individuals screened.

Due to the ***large numbers of requests*** and the ***limited number of audiometers*** available for loan, we ask that you ***schedule your screening to maximize use of the audiometer***. Please keep the loan period as short as possible. Do not exceed loan limits listed below.

NUMBER OF CHILDREN TO BE SCREENED	MAXIMUM LENGTH OF AUDIOMETER LOAN
0 -50	1 WEEK
51 - 100	2 WEEKS
101 - 250	3 WEEKS
251 - 500	4 WEEKS
501 - 750	6 WEEKS
751 AND ABOVE	8 WEEKS

Requests should be made as far as possible in advance of need and should be directed to:

Department of State Health Services
Health Screening Group
Mail Code 1818
Vision and Hearing Screening
1100 West 49th Street
PO Box 14937
Austin, Texas 78714-9347

Include the following information:

1. Name of organization applying for an audiometer loan.
2. Mailing address of organization.
3. County organization is located in.
4. Dates the audiometer will be used for screening.
5. Alternate choice of dates, if first choice cannot be met.
6. Person responsible for the audiometer.
7. Actual location for delivery by UPS (unable to deliver to P.O. Box or Rural Route).
8. Approximate number of people being screened.
9. Telephone number, including area code, for the organization.
10. Telephone number where the person responsible for the equipment can be reached.
11. List all persons who will be using the audiometer.

If the request is approved, the equipment will be shipped and insured at State expense.
THE BORROWER IS RESPONSIBLE FOR THE RETURN SHIPPING AND INSURING COSTS AND THE RETURN OF AUDIOMETER ON TIME.

The borrower will receive two copies of the **Property Loan Form.** ***Immediately*** upon receipt of the audiometer ***one form should be signed and returned to this office.*** Also included in this packet will be report forms for each audiometer in use. It is important that this ***completed*** report is ***returned with the audiometer.***

PHONE: (512) 776-7420
FAX: (512) 776-7256

DEPARTMENT OF STATE HEALTH SERVICES

MONTHLY HEARING SCREENING REPORT

Report Period: ***(select one)***

☐ January	☐ May	☐ September
☐ February	☐ June	☐ October
☐ March	☐ July	☐ November
☐ April	☐ August	☐ December

Loan Period: _____ **Inventory #** _____
Loaned to: _____ **City:** _____
County: _____ **HSR:** _____

**** * SUBMISSION OF THIS FORM IS IN ADDITION TO THE M-52 ANNUAL SCREENING REPORT * ****

DATE	CITY	SCHOOL	SCREENER	# SCREENED	# * REFERRED
			TOTAL		

***(NUMBER REFERRED)** = Number of children who do not respond to one or more frequencies in either ear on the second screening. Also includes children referred with signs or symptoms of hearing loss.

RETURN TO:
DEPARTMENT OF STATE HEALTH SERVICES
VISION, HEARING AND SPINAL SCREENING
MAIL CODE 1818
1100 WEST 49TH STREET
PO BOX 14937
AUSTIN, TEXAS 78714-9347