## **HEARING SCREENING REQUEST WAIVER**

		Schoo	l Year	
CDS code number	School district			
Address (number and street)	)		City	ZIP code
Name		Title		Date
Signature		Office Telephone Number		Email Address
				tenth and/or eleventh grade ning for tenth and/or eleventh
				alternative testing plan that wi
<ul> <li>those exposed to loud not</li> <li>pupils that have been ref</li> <li>pupils for whom there wa</li> <li>pupils who have not had</li> <li>any pupil who has enrolled</li> </ul>	erred for testi is a previousl a hearing tes	ing by a pa y docume at for three	arent or teacher; nted problem; years; and	
☐ We will follow the alternative hearing testing plan as described above.				
Please submit this form prior approved waiver ofhearing s requirements contained in Se	creening do	es not ex	_	
Submit this request by one of t	he following:			
California Department of He Services Systems of Care E Hearing Conservation Program MS 8103 P.O. Box 997413 Sacramento, CA 95899-7413 Attention: Health Program S	Division		DO NOT W Approv Reviewed by	/RITE IN THIS SPACE red □ Not approved □ Date

PM 359 Rev. (10/16)

☐ Fax: (916) 327-1106

☐ Email: <u>HearingConservationProgram@dhcs.ca.gov</u>