

Apply today. It's fast, easy, and free!

1. Complete this section. There is no obligation.

_____		Alternate Contact (First & Last) _____		
Last Name	First Name	MI	Relationship _____ Tel. Number (____) _____	
_____		CA	Your Local Phone Company's Name _____	
Street Address	City	State	Zip	Name on Phone Bill (First & Last)* _____
Your Telephone Number* (_____) _____		Ethnicity: <input type="checkbox"/> Caucasian <input type="checkbox"/> Latino <input type="checkbox"/> African American		
Email Address (optional) _____		<input type="checkbox"/> Native American <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> Other		
*Cannot be a cellular phone.		Age: <input type="checkbox"/> 18 or under <input type="checkbox"/> 19-35 <input type="checkbox"/> 36-55 <input type="checkbox"/> 56-75 <input type="checkbox"/> 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

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

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> CA State Licensed Medical Doctor | <input type="checkbox"/> CA Licensed Optometrist | <input type="checkbox"/> CA Licensed Audiologist | <input type="checkbox"/> CA Department of Rehabilitation Counselor |
| <input type="checkbox"/> CA Superintendent/Audiologist from the Fremont/Riverside School for the Deaf | <input type="checkbox"/> CA Licensed Hearing Aid Dispenser (see provision below)** | | |
| Impairment(s) of the Applicant: | <input type="checkbox"/> Deaf/Deafened | <input type="checkbox"/> Low Vision/Blind | <input type="checkbox"/> Hard of Hearing |
| | <input type="checkbox"/> Cognitive | <input type="checkbox"/> Mobility/Manipulation | <input type="checkbox"/> Speech |

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 1320 East Shaw, Suite 130

Oakland 1970 Broadway, Suite 650

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



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

