Infant Audiological Assessment & Diagnostic Center Modification

Date: _____

Agency Information		
Agency Name:		
Authorized Contact:	Title:	
E-mail Address:	Authorized Contact Phone:	
Agency Physical Address:		
City:	State:	Zip:
Mailing Address (if different):		
Agency Phone:	Toll-free:	Fax:

Updates

☐ **Employment of Audiologists (and Externs)** **(Attach copy of license)**

Name: **KY License #**
Name: **KY License #**
Name: **KY License #**

☐ **Termination of Employment of Audiologists (and Externs)**

Name: **Date:**
Name: **Date:**
Name: **Date:**

☐ **Change in Facility Information (name, address, phone/fax, email, etc.)** Effective Date:

☐ **Additional Location(s) address and phone/fax:**

☐ **Significant Modification to Policy or Procedures – Audiological Evaluation (attach documentation):**

On behalf of the agency, I certify that the answers above are true and complete.

_____ **Date:**
Authorized Representative

When complete, please submit this form, with all attachments to:

OCSHCN: Early Hearing Detection & Intervention
310 Whittington Parkway, Louisville KY 40222
FAX: 502-429-7160
Email: ehdi@ky.gov