

## **Application For Complimentary Directory Assistance Calls**

<u>Instructions</u>: To receive complimentary Sprint Directory Assistance Calls (with Call Completion) due to a qualifying disability, we ask that you complete the form below and obtain certification from your health professional.

Name	<u>Customer Information</u>
Addres	S
City/Sta	ate/Zip
Wireles	ss Phone Number
Sprint /	Account Number (if available)
	Health Professional Information
	I hereby certify that the above applicant is:
	<b>Legally Blind</b> (Visual acuity is 20/200 or less in the better eye with correcting glasses or widest diameter of visual field subtends an angular distance no greater than 20 degrees.)
	<b>Visually Disabled</b> (Regardless of optical measurement with respect to "legal blindness", is unable to read standard printed material.)
	<b>Physically Disabled</b> (Unable to read or use standard printed material, such as a telephone directory, as a result of a physical limitation.)
	<b>Cognitively Disabled</b> (Difficulty with short term memory, inability to sequence numbers.)
Name o	of Health Professional (please print):/
City/S	State/Phone Number (Required):
Signatu	re of Health Professional <b>or STAMP</b> Date
request ohone refundify, or qualified to my health this inforn	that Sprint provide complimentary Directory Assistance Calls (with Call Completion) for my exclusive use on the wirelest ferenced above. I understand and accept that this program is provided as a courtesy of Sprint and that Sprint may limit or cancel this program at any time. I understand and accept my responsibility to notify Sprint in the event I am no long to receive complimentary Sprint Directory Assistance Calls (with Call Completion). I hereby provide consent and authorism professional to provide the above private health information to Sprint, which also has my consent to collect and retained in professional to provide the above private health information to Sprint, which also has my consent to collect and retained below, I certify, that the information contained within this application is true and correct.
Signature	of Customer or Authorized Representative Full Name of Person Signing (please print) Date
	or difficulty completing this application? Contact Sprint® Accessibility Care toll-free at 5-7568. Return this completed form to Sprint:

Shawnee Mission, KS 66201
Please allow at least three business days for processing to be completed after this application has been received by Sprint. (*PLEASE NOTE*: Normal airtime charges apply. Service is not available while roaming off the Nationwide Sprint Network.)

KSOPHR0312 P.O. Box 29230