Oticon
Hearing with Our Hearts™

Practitioner Name: _____

Practice Name: _____

Address: _____

City: _____

State: _____

Zip Code: _____

Phone: _____

Email Address: _____

Oticon Account (if applicable): _____

Project Name: _____

Sponsoring Organization: _____

Organization Website/Tax ID #: _____

Briefly summary of the organization's mission and source of principal funding (100 words): _____

Description of the project (100 words): _____

Who will benefit: _____

Hearing instruments requested (number, type): _____

Will you personally dispense/fit the hearing instruments?: _____

If not, list the name(s) and professional affiliation of the practitioner(s) who will fit and dispense the instruments:

Date donation is needed: _____

Please indicate any other groups that you have applied to for donations for this project: _____

(followed by directions for submitting the application via email or US mail)

Oticon Hearing Foundation
580 Howard Avenue
Somerset, NJ 08873

Main 800.526.3921
Fax 732-865-7730