Application For Complimentary Directory Assistance Calls

Instructions: 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.

Customer Information

Name ______________________________

Address ______________________________

City/State/Zip______________________________

Wireless Phone Number ______________________________

Sprint Account Number (if available)______________________________

Health Professional Information

I hereby certify that the above applicant is:

☐ **Legally Blind** (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.)

☐ **Visually Disabled** (Regardless of optical measurement with respect to "legal blindness", is unable to read standard printed material.)

☐ **Physically Disabled** (Unable to read or use standard printed material, such as a telephone directory, as a result of a physical limitation.)

☐ **Cognitively Disabled** (Difficulty with short term memory, inability to sequence numbers.)

Name of Health Professional (please print): ____________________/____________________
Last Name First Name

City/State/Phone Number (Required): ______________________________

______________________________ ______/_____/_____
Signature of Health Professional **or STAMP** Date

Customer Certification & Consent

I request that Sprint provide complimentary Directory Assistance Calls (with Call Completion) for my exclusive use on the wireless phone referenced above. I understand and accept that this program is provided as a courtesy of Sprint and that Sprint may limit, modify, or cancel this program at any time. I understand and accept my responsibility to notify Sprint in the event I am no longer qualified to receive complimentary Sprint Directory Assistance Calls (with Call Completion). I hereby provide consent and authorize my health professional to provide the above private health information to Sprint, which also has my consent to collect and retain this information for the limited purpose of this application.

By signing 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

Questions or difficulty completing this application? Contact Sprint® Accessibility Care toll-free at **1-855-885-7568**.

Return this completed form to Sprint:

Fax: 1-877-877-3291 *OR* **Mail: Sprint® Accessibility Care**
KSOPHE0202
P.O. Box 29230
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.)