**Assistive Technology**

**Device Evergreening Checklist for Students with Hearing Loss**

A student-specific assistive technology (AT) device deployed by the Department of Education & Early Childhood Development (EECD) may be eligible for evergreening (replacement) if the device is not functioning properly and is no longer covered under warranty or is no longer meeting the student’s needs.

Evergreened devices must be returned to the student services AT designate at the district regional office.

**Did this student receive current device through the EECD AT application process?**

No If NO, this device is not eligible for evergreening. Please consult [AT Guidelines & Eligibility Criteria and documentation requirements](http://www.gov.nl.ca/edu/k12/studentsupportservices/assistive_tech.html)).

Yes If YES, please complete the following:

Current equipment is not functioning properly and is no longer covered under warranty **OR**

Current equipment is no longer meeting student’s needs

Issue with current device and/or why it is no longer meeting student’s needs:

Once replacement equipment is received, current equipment will be returned to

District DHH Itinerant **OR**  District Audiologist for redeployment by EECD

**Student Name**:

**AT To Be Replaced:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Manufacturer, Make & Model** | **Description** | **Serial Number(s)** | **Date/Yr Deployed** |
| Manufacturer:  Make:  Model: | Description:  # deployed: |  |  |
| Manufacturer:  Make:  Model: | Description:  # deployed: |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Manufacturer:  Make:  Model: | Description:  # deployed: |  |  |

**Replacement AT Requested:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Manufacturer, Make & Model** | **Description** | **# Required** | **If Audio Shoes Required** |
| Manufacturer:  Make:  Model: | Description: |  | Type |
| Manufacturer:  Make:  Model: | Description: |  | Number Required |
| Manufacturer:  Make:  Model: | Description: |  | Additional Information |

I certify that:

This student meets the criteria of Hearing Loss

This student is on my current DHH caseload

The information provided above is an accurate assessment of need

The use of this AT is recommended by this student’s program planning team.

|  |  |  |
| --- | --- | --- |
|  |  |  |

Signature of DHH Teacher completing this form Please type/print name Date

**Please attach this checklist to the student's Assistive Technology Application.**