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**Government of Newfoundland and Labrador**

**Education and Early Childhood Development**

**Assistive Technology**

**Referral for Hushh-ups**

Hushh-ups must be transferred to new classrooms as student moves within the school. School may apply for replacement Hushh-ups after 3 years of usage or if the student is changing schools and the new school does not have Hushh-ups available for use.

Student’s Name:

Has this student previously received Hushh-ups? [ ]  Yes [ ]  No

Have Hushh-ups already available at this school been considered and factored into this request? [ ]  Yes [ ]  No Please explain:

Is this a new school for the student? [ ]  Yes [ ]  No

* If yes, are there other students with hearing impairments who require hush-ups that are transitioning to/already attending this school? [ ]  Yes [ ]  No
	+ If yes, please explain how this has been factored into current request:

# Quantity Required

|  |  |  |
| --- | --- | --- |
| Classrooms  | # desks with attached seat (4 legs) | # desks with separate chair & table (8 legs) |
| [ ] Homeroom class |       |       |
| [ ] 1st adjacent  |       |       |
| [ ]  2nd adjacent  |       |       |
| [ ]  3rd adjacent |       |       |
|  | **Total #** of desks with 4 legs:      | **Total #** of desks with 8 legs:      |
| **Hushhups come in boxes of 120. Based on this and information above, specify number of boxes requested:** |

Presence of soundfield system: [ ]  Yes [ ]  No

Has FM system been deployed to/requested for this student: [ ]  Yes [ ]  No

I certify that:

[ ]  This student meets the criteria of Hearing Loss

[ ]  This student is on my current DHH caseload

[ ]  An evaluation of the student’s classroom environment has determined that Hushh-ups would be a valuable support to the student’s learning

[ ]  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.**