



# Illinois Telecommunications Access Corporation

800-841-6167 V/TTY • 217-698-0942 Fax

## ITAC ELECTROLARYNX APPLICATION

### CLIENT INSTRUCTIONS:

**1. Complete the application.**

Applicant completes all client information.

Speech-Language pathologist completes the certification information.

**2. Copy of your current phone bill.**

Remit a copy of either your landline or cell phone bill. Include the pages that list name, address, phone number, and all taxes & fees.

**3. Proof of residency.**

Copy of driver's license, State ID, or piece of mail with the same address as listed on the application.

**4. Send this original, completed application to:**

**ITAC**

3001 Montvale Drive, Suite. A  
Springfield, IL 62704

Last 4 digits of SS#: XXX-XX-\_\_\_\_\_

Client's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Apt. Number: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Landline Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

Landline Phone Company: \_\_\_\_\_ Cell Phone Company: \_\_\_\_\_

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*(If under 18, parent or guardian signature required)*

### CERTIFICATION FOR USE OF ELECTROLARYNX

**By providing the following information, you are verifying that the above-named applicant has had a laryngectomy requiring an artificial larynx to communicate.**

Name of Speech-Language Pathologist: \_\_\_\_\_

Title: \_\_\_\_\_ State License Number: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Area Code & Telephone Number: \_\_\_\_\_ Initial here if cell phone service verified \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Last 4 Digits of Applicants SS# \_\_\_\_\_