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Winnipeg, MB R3T 3K7
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Fax: 204-942-1428
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REHABILITATION EQUIPMENT FUNDING AUTHORIZATION FORM

Date: _____

Dear Resident/Family/POA

Re: _____

In order to maximize the comfort, function and safety of the above-named resident, the following equipment is recommended:

To be completed by person in charge of financial affairs:

I hereby provide authorization to order the above noted equipment and accept responsibility for payment. Cost is estimated within 10% _____

In most instances, the responsible party will be billed directly by vendor.

Date: _____

Authorization by (please print): _____

Address: _____

Signature: _____

Specific supplier preferred? Yes _____ No _____

If yes, please specify: _____

A. To be completed by therapist:

Name and Designation (please print):

Signature of Therapist:

B. To be completed by physician:

Name: (please print) _____

Physician Registration #: _____

Signature: _____