Spina Bifida Families of Canada
We've got your backs.

MEDICAL TRAVEL SUPPORT FUND
CONFIRMATION OF APPOINTMENT

This form is to be completed by a medical professional who can confirm the nature and date of the treatment. The completed form must accompany the Medical Travel Support Fund Application. General inquiries can be sent to hello@sbcan.ca.

Applicant Information

First Name	Last Name	Date of birth (yyyy-mm-dd)
		- -

Practitioner Information

First Name	Last Name	Office Phone Number

Treatment Information

Treatment Facility Name			Date of treatment (yyyy-mm-dd)
			- -
Address	City	Province	Postal Code

Confirmation of Eligibility

I hereby confirm that the above patient has been or has an appointment to be treated at the treatment facility above for spina bifida related medical issues.

I am a medical professional (select one):

- Physician
- Optometrist
- Psychologist
- Psychological Associate
- Nurse Practitioner
- Registered Nurse
- Chiropractor
- Physiotherapist
- Occupational Therapist
- Social Worker
- Audiologist
- Speech Language Pathologist

Signature

____
Signature (your typed name is acceptable)

____
Date

____
Practitioner Number (optional)

The personal information you provide in this form will be kept confidential and used solely for the purpose of assessing the applicant's eligibility for the Medical Travel Support Fund.