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

MEDICAL TRAVEL SUPPORT FUND APPLICATION

Email your completed Application, along with the Confirmation of Appointment form, to hello@sbcan.ca. Please refer to the Medical Travel Support Fund Guidelines for details on eligibility. General inquiries can be sent to hello@sbcan.ca.

Applicant Information

First Name	Last Name		Date of birth (yyyy-mm-dd) – –
Address	City	Province	Postal Code
Phone Number	Email Address		

Parent/Guardian Information (if applicant is under 18 years of age)

First Name	Last Name		Date of birth (yyyy-mm-dd) – –
Address	City	Province	Postal Code
Phone Number	Email Address		

Treatment Information

(Attach a copy the Medical Travel Support Fund Confirmation of Appointment Form, to be completed by a medical professional)

Treatment Facility Name			Date of treatment (yyyy-mm-dd) – –
Address	City	Province	Postal Code
Tell us how this treatment will support your (or the applicant's) development, quality of life, or overall well-being:			

Expenses

(If travel has not yet occurred, please provide estimated costs. If your application is approved, you will be asked to provide receipts/proof of travel before funding is released.)

Accommodation	$
Transportation (not including mileage where travelling by car)	$
Fuel/EV (Approved applications will receive 68¢ per km for a round trip from home to treatment centre. Please attach a screenshot of Google maps that displays the distance.)	$
Parking	$
Total amount of funding requested:	$

Have you sought and/or are you in receipt of funds from any other source/organization/agency in respect of these expenses?	◉ Yes ○ No

Please confirm your eligibility

- ☐ I am a Canadian citizen or permanent resident with spina bifida traveling for medical treatment (or their parent/guardian), OR I am a Canadian citizen or permanent resident that is a person pregnant with a baby with spina bifida.
- ☐ The treatment is directly related to spina bifida.
- ☐ I will be traveling at least 150kms from my home within Canada to another location in Canada for this treatment.
- ☐ I confirm that the information provided in this application for funds is accurate and complete.
- ☐ I acknowledge that incomplete applications will not be accepted.

Signature

_____ _____

Signature (your typed name is acceptable) Date

The personal information you provide in the course of completing this form will be kept confidential and used solely for the purpose of assessing your application for the Medical Travel Support Fund.