BY EMAIL

TRAVEL FORM FOR MEDICAL REASONS

Part A

This form must be duly completed and returned by email to Transport Services at the latest, 10 days after the medical appointment.

Part B (Reserved for the employee)

Name of employee: _____ Payroll #: _____

Community: _____ Date of Birth: _____/_____/_____
Y M D

For medical services to: ☐ Same as above ☐ Other (_____)
Specify

Kinship: ☐ Spouse ☐ Child ☐ Other (_____)
Specify

Name: _____ Date of Birth: _____/_____/_____
Y M D

Travel Itinerary

Date	From	To
Departure: _____/_____/_____ (Y / M / D)	_____	_____
Return: _____/_____/_____ (Y / M / D)	_____	_____

Part C (Reserved for the attending physician)

I examined the patient designated in Part B of this form on:

Date: _____/_____/_____ (Y / M / D) Location: _____ (town/ city)

I certify that the medical care services obtained are not offered in the Nunavik community where the patient is currently residing.

Name of Physician: _____

Specialty: _____

Permit number: _____

Address: _____

Phone number: _____

Signature: _____