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Assessment Equipment Program Application

Medicare #: _____

Application Date: _____

Health Care ID #: _____

Expiry Date: _____

1.) Applicant's Name: _____

Date of Birth: _____

*If applicant is a child, please use child's name

(YY/MM/DD)

Address: _____

Street

City

Postal Code

Telephone Number

Next of Kin: _____

Relationship: _____

Diagnosis: _____

Functional Disability: _____

Will Assessment be performed in school? Yes No

If yes, what is the name of the school? _____

2.) Rehabilitation Equipment for assessment only (include complete ordering information – brand, catalogue number, size, etc.)

3.) Referring Party: _____

Name (please print clearly)

Signature

Profession

Date

Work Address

Telephone

Street

City

Postal Code

Ship to: Referring Party Applicant

Billed to (\$36 per item): Referring Party Applicant Other

If other please provide address: _____

Street

City

Postal Code

Telephone Number

NOTE: On completion of Assessment, the user is expected to cover the cost of returning equipment to Easter Seals New Brunswick. Easter Seals New Brunswick assumes the responsibility for shipping of equipment to the user. If any further information is required, please call or fax Easter Seals New Brunswick at the numbers below.

The Assessment Equipment Program at Easter Seals New Brunswick is made possible by the many generous suppliers of rehabilitative equipment who loan the equipment to Easter Seals New Brunswick.