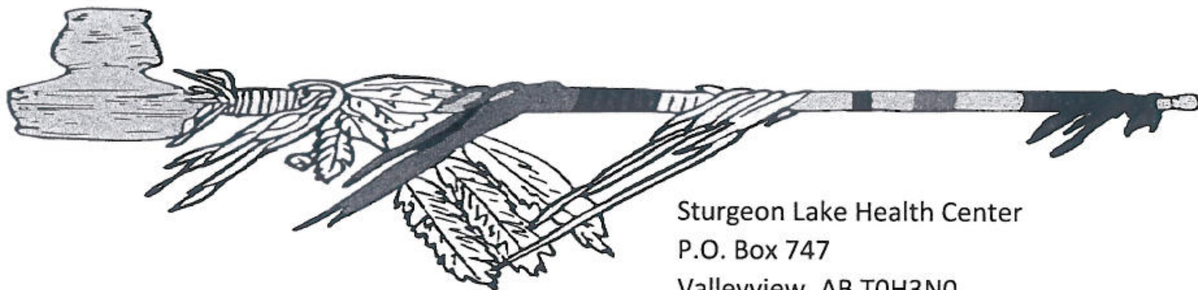

Sturgeon Lake Health Center
P.O. Box 747
Valleyview, AB T0H3N0

MEDICAL TRANSPORTATION REIMBURSEMENT FORM

DRIVERS NAME & ADDRESS: ______________________________

____

____

PHONE NUMBER ______________________________

PATIENTS NAME & ADDRESS: ______________________________

____

____

____

PHONE NUMBER ______________________________

BAND	TREATY #	PERSON HEALTH CARE #

APPOINTMENT: ______________________________

____

____

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MEALS	ROOMS	MILEAGE	RATE	TOTAL MILEAGE	TOTAL CLAIM

********* RECEIPTS MUST BE ATTACHED FOR MEALS & ROOMS*********

I AM REQUESTING REIMBURSEMENT FOR EXPENSES INCURRED FOR TRAVELING TO DOCTORS APPOINTMENT

SIGNATURE	DATE	VERIFIED BY

DATE PAID	AMOUNT	CK. #	ACCOUNT	PROCESSED BY