



Okotoks CARE Medical Eligibility Verification Form

This form is to be completed by a regulated health care professional to support an application for the Okotoks CARE Program and verify a disability.

Applicant Information

Applicant Name:	
Date of Birth (DD/MM/YYYY)	
Address:	
Phone Number:	

Health Care Professional Information

Health Care Professional Name:	
Professional Designation	☐ Physician ☐ Nurse Practitioner ☐ Occupational Therapist ☐ Registered Nurse ☐ Other Regulated Health Professional _____
Clinic / Organization:	
Phone Number	
Email:	
☐ The applicant has a disability defined as a substantial and/or long-term impairment of mental or physical functioning.	

Professional Declaration

I certify that, based on my professional knowledge and assessment of this individual, the information provided on this form is accurate and supports the applicant's eligibility for transportation assistance through the Okotoks CARE Program.	
Signature:	Date (DD/MM/YYYY):

Applicant Authorization

I authorize the health care professional identified above to provide this information to the Okotoks Family Resource Centre and/or the Town of Okotoks for the purpose of determining eligibility for the Okotoks CARE Program.	
I understand that only information relevant to determining program eligibility will be collected and reviewed.	
Applicant Name	Applicant Signature
Date (DD/MM/YYYY):	