NORTHWEST TERRITORIES POWER CORPORATION
Empowering Communities

CERTIFICATE FOR MEDICAL TRAVEL

PLEASE PRINT CLEARLY & RETURN BY FAX TO (867) 874-5229
Form not valid until ALL fields are completed

NAME OF CLINIC: _____ DATE: _____

NAME OF MEDICAL/DENTAL PRACTITIONER: _____

COMMUNITY: _____ PHONE NO.: _____

NOTE: Transportation under this authority should not be authorized when it could be deferred until employee is out on vacation.

Name of patient: _____ DOB: _____

Name of NTPC employee (if different than patient): _____

I have examined the above named patient. It is my opinion that medical/dental care is **URGENTLY** required and not available in _____.
(name of town/city)

The nearest center where this attention is available is _____
(name of clinic/hospital)

located in _____.
(name of town/city)

Date and time of appointment(s): _____

Is this procedure **ELECTIVE** or **NOT ELECTIVE**? (please circle one)

Does the patient require an escort (circle)? **YES** **NO**

If yes, please give reason why an escort is required**:** _____

_____

Medical/dental diagnoses for travel/ I.C.D. 9 Code: _____

I hereby certify that the information provided on this form is accurate.

_____ _____
(signature of medical/dental practitioner) **(Date)**

Form completed by: _____ Date: _____

NTPC USE ONLY

Expected Departure Date: _____Time:_____

Expected Return Date: _____Time:_____