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FIRST RESPONDERS TRAVEL CLAIM FORM

Name: ____ Date: ______________________

Fire Department/MFR Agency: ____

Mailing address: ____

____

Telephone: ___________________ Cell: _________________ Fax: _________________

Date, time and location of call: ____

____

Accompanied patient to: ____

(indicate health care facility)

Mileage: _______ km @ $0.39/km = $ __________ ***or*** Transportation cost: $ ____________
(e.g. taxi; attach receipt)

Signature: ________________________________ Total claim: $ _________________

Note: Payment of this claim will be issued to the Fire Department or MFR Agency.

Submit completed form to:

EHS MFR Services
239 Brownlow Avenue, Suite 300
Dartmouth, NS B3B 2B2
Fax: (902) 832-8602

Approved by: ______________________________ Date: _______________________
MFR Coordinator,
EHS Ground Ambulance Operations

Please see Program Document No. 12017.00