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*** Transcription 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:

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

Approved by: ____________________________________ Date: ___________________________
Regional Manager,
EHS Ground Ambulance Operations

Please see Program Document No. 12017.00