



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: _____
*Regional Manager,
EHS Ground Ambulance Operations*