



**REQUEST FOR DATE(S) OF VISIT(S) FOR INCOME TAX PURPOSES**

Client's Name: \_\_\_\_\_

Address: \_\_\_\_\_ Community/Town: \_\_\_\_\_

Postal Code: \_\_\_\_\_ Telephone #: \_\_\_\_\_

MCP #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Provide a brief description of date range requested and identify specific facility(s)/site(s) for visits:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Signature of Requestor:** \_\_\_\_\_ **Date of Request:** \_\_\_\_\_

If the person requesting information is not the client, state the relationship and authority to do so. The fee associated with this request is \$10.00 per request/per client. Please submit payment with request. List of dates(s) of visit(s) will be forwarded via mail to the requestor. Please allow 2 – 3 weeks for processing.

\_\_\_\_\_  
**Signature of Authorized Representative**

\_\_\_\_\_  
**Relationship**

*Please complete and forward to:*

*Accounts Receivable  
Financial Services Department  
James Paton Memorial Regional Health Centre  
125 Trans Canada Highway  
Gander, NL A1V 1P7*