



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

Client's Name: _____
Mailing Address: _____ Community/Town: _____
Postal Code: _____ Telephone #: _____
MCP #: _____ Date of Birth: _____

The list of date(s) of visit(s) provided to you will include visits from all Central Health facilities that use electronic registration. If you require a list of visit(s) from a Central Health medical clinic, community health centre or hospital, please provide the clinic(s) name below.

Central Health will only provide you with the date(s) of visit(s) for the last calendar year, unless otherwise specified on your request.

Specify facility and year(s): _____

Clients 16 and over must sign their own form.

Signature of Requestor Date

If the person requesting information is not the client, state the relationship and authority to do so.

Signature of Authorized Representative Relationship

Please note that date(s) of visit(s) for a clinic/facility not operated by Central Health must be directed to that specific clinic/facility.

The fee associated with this request is \$10.00 (HST included) per client. Please submit payment with your request. The list of date(s) of visit(s) will be mailed to the requestor. Please allow up to 60 days for processing.

If paying by cheque, please make cheque payable to Central Health.

If paying by Visa, Mastercard or American Express, please fill out the following information:

Name (as it appears on the card): _____
Credit Card #: _____ Expiry: _____ CVC: _____

Return options:

By mail: Accounts Receivable – Central Health
James Paton Memorial Regional Health Centre
125 Trans Canada Highway, Gander, NL A1V 1P7

By fax: (709) 256-5651

By email: accounts.receivable@centralhealth.nl.ca

For inquiries concerning the processing of this form, please call 709-256-5994

