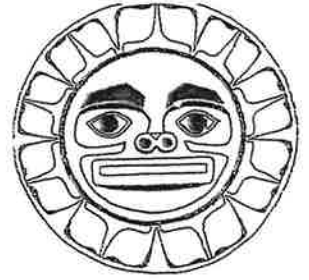


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Ehattesaht Tribe
Attention: Patient Travel Worker
Fax: (250) 761 – 4156



Patient Name: _____ Appt. Date & Time: _____

Dr. or Clinic Name: _____

★ Please have Dr. or Clinic confirm that appointment is one of the following: (Circle one)
Specialist Appointment Hospital Appointment Referred Appointment.
Dental Appointment Other _____

Any additional comments (To support your travel request):

This is to confirm that the above noted patient attended their scheduled appointment

Dr. or Nurse Sign here & Date

★ TO PATIENT: This must be returned to the Band Office prior to any additional travel being issued. Travel will not be issued unless appointment is required to travel away from our nearest services.

Stamp here:

