APPLICATION FOR EXEMPTION

Name: _____

PHN: _____ Date of birth: _____
(Alberta Health Care Number)

Street address: _____ City: _____

Province: _____ Postal code: _____

Phone (home): (780) _____ Phone (work): (780) _____

Email address: _____

I feel that I am unable to pay for *non-essential (uninsured, de-listed)* health services because:

As such, I request consideration for exemption.

Signature of patient: _____ Date:_____, 2007
(or guardian)

Signature of witness: _____

Applications will be reviewed by our Community Support Committee.