Applicant's Last Name	First Name	Health Number (10 digits)	Version

Section 4 – Signatures

Physician/Nurse Practitioner Signature (if applicable)

I hereby certify that I have personally assessed the applicant in person and determined that the applicant has a chronic physical disability requiring regular use of the prescribed pressure modification device(s).

☐ Physician ☐ Nurse Practitioner

Physician/Nurse Practitioner's Last Name	Physician/Nurse Practitioner's First Name
Business Telephone Number ext.	Ontario Health Insurance Billing No (5 or 6 digits)

Physician/Nurse Practitioner's Signature	Date Signed (yyyy/mm/dd)

Authorizer's Signature and Confirmation of Applicant's Eligibility

I hereby certify that I have personally assessed the applicant in person and determined that the applicant meets ADP eligibility criteria. I have also measured and/or authorized the equipment described on this form and advised the applicant or his/her agent that he/she may purchase the device through an ADP Registered Vendor of their choice and have provided a list of ADP Registered Vendors in the applicant's community for their use.

Authorizer's Last Name	Authorizer's First Name
Business Telephone Number ext.	ADP Authorizer Registration Number

Authorizer's Signature	Assessment Date (yyyy/mm/dd)

Certified Fitter's Signature

I hereby certify that as recommended by the Physician/Nurse Practitioner/Authorizer/Burn Team/Lymphedema Team, I have measured the applicant named above and subsequently fitted the pressure modification device to the applicant's satisfaction. I have also trained the applicant on how to apply, remove, use, care for, and maintain the device.

Fitter's Last Name	Fitter's First Name
Business Telephone Number ext.	ADP Certified Fitter's Registration Number

Fitter's Signature	Final Fitting Date (yyyy/mm/dd)

Clinic (if applicable)

Clinic Name

ADP Clinic Number	Business Telephone Number ext.