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

Section 4 – Signatures

Physician/Nurse Practitioner Signature

I hereby certify that I have personally assessed the applicant in person and determined that the applicant has a chronic respiratory illness or disability requiring the long-term use of the device(s) or supplies specified above.

☐ Physician ☐ Nurse Practitioner

Physician/Nurse Practitioner Last Name	Physician/Nurse Practitioner First Name
Business Telephone Number ext.	Ontario Health Insurance Billing No (5 or 6 digits)
Physician/Nurse Practitioner Signature	Date Signed (yyyy/mm/dd)

Clinic providing Sleep Lab diagnosis (for Positive Airway Pressure Systems applications only)

Clinic Name	
ADP Clinic Number	Business Telephone Number ext.

Vendor Information

I hereby certify that the applicant has received or will receive the item(s) as authorized and the information provided is true and accurate.

Vendor Business Name	ADP Vendor Registration Number
Vendor Representative's Last Name	Vendor Representative's First Name
Position Title	Business Telephone Number ext.
Vendor Location	

Vendor Representative's Signature	Date Signed (yyyy/mm/dd)	Vendor Invoice Number

Equipment Specifications

ADP Device Code	Description of Item (Make & Model)	Serial Number	ADP Portion ($)	Client Portion ($)

This page must be completed and submitted