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

Section 4 – Signatures

Authorizer's Signature

I hereby certify that I have personally assessed the applicant named on this form in person, I have confirmed his/her eligibility for funding assistance in accordance with all ADP funding guidelines, I have authorized the equipment described on this form based on a comprehensive clinical assessment, and have taken all safety and environmental concerns into consideration. I have advised the applicant or his/her agent that (i) he/she may purchase the ADP approved equipment from the ADP Registered Vendor of their choice, and have provided a list of ADP Registered Vendors in the applicant's community for their use or (ii) have informed the applicant or his/her agent about the policies and procedures of the ADP Central Equipment Pool for High Technology Wheelchairs (CEP).

Authorizer's Last Name	Authorizer's First Name
Berry	Emma
Business Telephone Number	**ADP Authorizer Registration Number**
416-443-1492 ext. 522	312111
Authorizer's Signature	**Assessment Date (yyyy/mm/dd)**
	1957/02/15

Vendor/Vendor Representative Information

1. Vendor Business Name: Inkblot Therapy — ADP Vendor Registration Number: 288027

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 Representative (Last Name, First Name)	Position Title
Cross, Ruby	Claims Team Lead
Vendor Location	**Business Telephone Number**
109 Emerald Court	647-064-5802 ext. 579
Vendor Representative's Signature	**Date Signed (yyyy/mm/dd)**
	1902/05/13

2. Vendor Business Name: Tactio Health Group — ADP Vendor Registration Number: 133967

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 Representative (Last Name, First Name)	Position Title
Thomas, Payton	Insurance Claims Analyst
Vendor Location	**Business Telephone Number**
278 Meadowview Court	226-624-6732 ext. 825
Vendor Representative's Signature	**Date Signed (yyyy/mm/dd)**
	1962/08/03

Equipment Specifications (Ambulation Aids Only)

Vendor Invoice Number	Vendor's ADP Registration Number	Base Device
816	593125	
ADP Device Code (Base Device)	**Description of Item (Make & Model)**	**ADP Portion**
965117	Omron Platinum	95029
Serial Number		**Client Portion**
698876535		30843

Proof of Delivery

I confirm that I have received the mobility device described above and that I have received a fully itemized invoice from the vendor for the device described above. I understand that the vendor may bill me for the equipment if I do not meet the ADP's criteria for funding.

Signature		Date of Delivery (yyyy/mm/dd)
	☐ Applicant ☑ Agent	1955/07/13

This page must be completed and submitted