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
Woods	Skyler
Business Telephone Number	**Ontario Health Insurance Billing No (5 or 6 digits)**
647-161-1378 ext. 391	394346
Physician/Nurse Practitioner Signature	**Date Signed (yyyy/mm/dd)**
	2021/09/17

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

Clinic Name	
Harmony Healthcare Centre	
ADP Clinic Number	**Business Telephone Number**
43885	343-381-9750 ext. 257

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
Babylon	360430
Vendor Representative's Last Name	**Vendor Representative's First Name**
Carroll	Ella
Position Title	**Business Telephone Number**
Claims Administrator	705-046-6992 ext. 740
Vendor Location	
973 Cedar Crescent	

Vendor Representative's Signature	Date Signed (yyyy/mm/dd)	Vendor Invoice Number
	2015/05/16	255

Equipment Specifications

ADP Device Code	Description of Item (Make & Model)	Serial Number	ADP Portion ($)	Client Portion ($)
35646	Abbott FreeStyle	51810	870□14	231□75
32243	Ethicon Echelon	26208	68□65	265□54
23555	Karl Storz	88590	256□77	300□99
50381	Stryker Norm-O	50190	964□94	803□15
83074	Leica DM500	82893	13□09	623□74
84470	Baxter Sigma	18833	344□79	992□3
67148	GE Optima	46206	512□28	677□38

This page must be completed and submitted