Attestation of medication delivery coverage criteria

Dear BC Transplant,

I am writing to request transplant medication delivery coverage that is outside of my current transplant pharmacy's delivery services. I meet the following criteria:

Patient Initials	Criteria (must initial 1, 2, 3, and 3.a and/or 3.b):
	1. I am outside of my current transplant pharmacy's free delivery radius (if applicable), AND
	2. I am financially unable to cover the cost of delivery as I am receiving income assistance or disability assistance: **Specify: ____**, AND
	3. I am unable to access a transplant pharmacy within my community, either because:
	a. I have a disability that prevents me from picking up my medications from the nearest transplant pharmacy, OR
	b. I live more than 15 kilometers away from the nearest transplant pharmacy.

I understand that delivery coverage will be valid until the end of the calendar year (Dec 31) upon approval, after which a new application will need to be sent in. I understand attestations may be audited and documentation showing enrollment in an income assistance or disability assistance program may be requested. If unable to provide documentation, all prior delivery charges will be subject to re-payment.

I hereby certify that, to the best of my knowledge, the provided information is true and accurate.

Transplant Recipient Name:	Date of Birth (Day/Month/Year):
Home Address:	Delivery address (if different from home address):
Email:	
Signature:	Date (Day/Month/Year):

Please return this form to your transplant pharmacy.