HEALTH AND SOCIAL DEVELOPMENT

PROTECTED MEDIUM
CONTAINS PERSONAL OR SENSITIVE INFORMATION

NON-INSURED HEALTH BENEFITS

TRANSLATION SERVICES CLAIM

To: Medical Transportation Department

Section 1: Please issue cheque to *(All sections are mandatory and must be completed)*		
Translator Name:		**N Number***(if applicable)***:**
Address:		
City/Town:	**Province:**	**Postal Code:**
Section 2: Translation services information		
Translated For:		**N Number:**
ADS Trip I.D. #:	**Date(s):**	
Section 3: Authorization		
Authorized By:		