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 (example: I am receiving income assistance or disability assistance through the Ministry of Social Development and Poverty Reduction), 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 hereby certify that, to the best of my knowledge, the provided information is true and accurate.

Name: _____

Date of Birth (Day/Month/Year): _____

Email: _____

Mailing address: _____

_____

Signature: _____

Date (Day/Month/Year): _____

Please return this form to your transplant pharmacy.