SOCIAL DEVELOPMENT
Health Services Unit
P.O. Box 5500, Frederiction, N.B., E3B 5G4
Toll Free: 1-844-551-3015
Fax: (506) 453-3960

New Nouveau Brunswick CANADA

DÉVELOPPEMENT SOCIAL
Unité des services de santé
C.P. 5500, Fredericton N.-B., E3B 5G4
Sans Frais: 1-844-551-3015
Télécopieur: (506) 453-3960

Clear / Effacer

APPLICATION FOR EQUIPMENT MAINTENANCE

PART A : CLIENT INFORMATION

LAST NAME	FIRST NAME	DATE OF BIRTH
ADDRESS	**CITY, TOWN, VILLAGE**	**POSTAL CODE**
TELEPHONE	**HEALTH CARD NUMBER**	**PRIVATE INSURANCE**
		Yes ☐ No ☐

PART B : EQUIPMENT INFORMATION & VENDOR INFORMATION

FIXED CPAP ☐ AUTO SET CPAP ☐ BPAP ☐

MAKE	MODEL	SERIAL NUMBER
AGE OF EQUIPEMENT	**VENDOR**	**VENDOR ID NUMBER**

Product & Equipment	Please provide the brand and serial number where applicable. In case of repairs, please attach the appropriate Service Technician report.		Service Dates	COST
Repairs	☐			$
Mask	☐			$
Supplies	☐			$
Other	☐			$
			TOTAL	$ 0.00

I am applying for coverage of repairs and modifications for the equipment listed in Part B of this form. I understand that if this request is approved, repairs, maintenance and replacement of essential accessories for the listed equipment will be funded by Social Development, provided my Health Card remains active with the proper coverage and I agree to the following terms and conditions of the Equipment Loan Agreement.

1. I confirm that I own this equipment.
2. I will care for this equipment as per the instructions received from my therapist, supplier or service technician.
3. I will have all repairs and maintenance completed by a certified service technician.
4. I will operate this equipment safely.
5. This agreement will terminate when this equipment is replaced or no longer required.

Client or Legal Guardian Signature: _____ Date: _____

If the equipment is over 5 years of age, have you verified that the equipment is still functioning properly?	☐ YES	☐ NO
Is the equipment in question still meeting the client's needs?	☐ YES	☐ NO
All necessary documentation specified in the Health Services Guidelines is included with this application.	☐ YES	☐ NO

Vendor Signature : _____ Date : _____

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APPROVED / APPROVEE	☐	REFUSED / REFUSE	☐	PENDING INFO / EN ATTENTE D'INFO	☐

PLEASE SUBMIT DOCUMENT WITH YOUR BILLING

APPROVAL NUMBER / NUMERO D'APPROBATION

Administrator
Administrateur _____ Date : _____

EXPIRES / EXPIRE :

REGISTERED / ENREGISTRER DATE : _____