

MEDICAL SERVICES BRANCH

Submit request to: MINISTRY OF HEALTH Medical Services Branch

3475 Albert Street – 2nd Floor Regina, Saskatchewan S4S 6X6 PHONE: 1-800-667-7523 or 306-798-0013 FAX: 306-798-1124 or

caseworkunitmsb@health.gov.sk.ca

MEDICAL STATEMENT REQUEST APPLICATION

Medical Statements are listings of physician services, the date of service, and the community where the service was provided, and services received in the hospital. Completion of this application allows Medical Services to request this information on your behalf.

Please fill out one application per person requiring a medical statement **Applicant Information** Family Name Given Name Date of Birth (DD-MM-YYYY) Health Services Number (9 digit) Male \square Female \square Number and Street, Concession, Other City or Town Apt. No. Province/State Country Postal Code (if in Canada) Contact Phone Number (10-digit) Please select the statement that you require: ☐ Physician Statement ☐ Hospital Statement **Section 1 – Relationship to Applicant** A - □ - Children under 18 years of age - Parents **MUST** sign request $B - \Box$ - Other (specify) Is the Power of Attorney (POA) or Executor signing on behalf of the applicant? YES □ NO □ YES, then copies of the POA or copy of Will or Letter of Administration documents MUST be attached PRINT NAME IF GUARDIAN/TRUSTEE/POWER OF ATTORNEY/EXECUTOR/WITNESS Section 2 – Third Party Agency Release (if applicable) requested by _____ **Section 3 – Request Information** Time Frame (i.e. January 1, 2014 to December 31, 2014) **Section 4 – Signature (REQUIRED)** Signature of Applicant_____ Date Please circle one of the following APPLICANT/GUARDIAN / TRUSTEE / POWER OF ATTORNEY/EXECUTOR/WITNESS A witness is necessary if Applicant signs with an "X" or a mark.