



205 - 5668 192<sup>nd</sup> Surrey, BC V3S 2V7  
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TNDS:

PLEASE FILL OUT ALL FIELDS BELOW - THIS FORM DOES NOT NEED TO BE FILLED OUT BY YOUR DOCTOR

## Medical Practitioner's Information

Name: \_\_\_\_\_

Gender: \_\_\_\_\_

Address: Street: \_\_\_\_\_ City: \_\_\_\_\_  
Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

How long have you been attending this office? \_\_\_\_\_

Type of Physician: Family Doctor  Specialist  Nurse Practitioner

## Patient's Information

Name: \_\_\_\_\_

Address: Street: \_\_\_\_\_ City: \_\_\_\_\_  
Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Email: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Date of Birth: (YYYY/MM/DD) \_\_\_\_\_ Gender: \_\_\_\_\_

I hereby authorize the above medical practitioner to release any and all information pertaining to my Disability Tax Credit claim to True North Disability Services, and for True North Disability Services to release any information pertaining to my Disability Tax Credit claim to the medical practitioner above.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_