



Mohawks of the Bay of Quinte
MEDICAL TRANSPORTATION
Confirmation of Attendance

This is to certify that _____ Band Number _____
received professional services from:

(Name & address of Professional in block letters)

Date: _____ Time of Apt: _____

Receptionist/Office Signature: _____ *(or affix an official stamp below)*

Client's Signature: _____

Driver's Name: _____

Drivers Mailing Address: _____

Pick-Up Time: _____ Return Time : _____

FOR CWC OFFICE USE ONLY

MTC Signature: _____ Date: _____

Signing Authority: _____

Account Code: **411000PATIEN** Trip Allowance: \$ _____

Other Benefits: \$ _____

Total Travel Allowance: \$ _____

****Not necessary for a physician to sign**