



MAIL FORM TO:
P.O. Box 9000 St. John's NL A1A 3B8

CALL US AT:
709.778.1000
1.800.563.9000

EMAIL FORM TO:
info@workplacenl.ca

VISIT US AT:
workplacenl.ca

FAX FORM TO:
709.778.1302
1.800.276.5257

Health Care Devices and Supplies Prescription

Please indicate applicable number
Claim number (worker): | | | | | | | |

[Click here to view a list of tendered items](#)

Worker's last name	Worker's first name
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Items prescribed: Note: Please identify model/catalogue number and sizing if applicable.	Rationale (in relation to compensable injury):
If the above item cannot be obtained please note the best alternative below.	
Has this item been trialed by the worker? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is this a replacement item? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Important: Online items cannot be purchased by WorkplaceNL

Name and professional designation: _____	
Organization: _____	Phone number: _____
Signature: _____	Date: