

WorkplaceNL

Mail form to:
P.O. Box 9000
146-148 Forest Road
St. John's, NL
A1A 3B8
Fax form to:
f 709.778.1302

Call us at:
t 709.778.1000
t 1.800.563.9000
Visit us at:
workplacenl.ca

Health Care Devices & Supplies Prescription

Please indicate applicable number

CLAIM NUMBER (Worker)

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

Worker's Last Name	Worker's First Name
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ITEM(S) PRESCRIBED

Note: Please identify model/catalogue no. 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 # _____
Signature: _____	Date: