



APPLICATION FOR FINANCIAL ASSISTANCE (SERVICE PROVIDER)

(Note: only one application need be submitted. An application form is to be submitted by either the member or the service provider.)

**Name of Client Receiving the Services:**

Is the client a (please circle): First Responder    Retiree    Veteran    Partner or spouse, or dependant

First responder affiliation (please circle):            Police            Fire            Paramedic

**Service Provider – name, address and contact means:**

**Clinician Designation and Registration Number (if applicable):**

I \_\_\_\_\_ (name of clinician) confirm that  
\_\_\_\_\_ (name of person) is currently receiving treatment  
from me. I anticipate this person will require \_\_\_\_\_ (number of sessions) sessions with me. I  
understand that I can only bill the Foundation to a maximum of \$1000.00 for the calendar year.

I \_\_\_\_\_ (name of clinician) agree to receive payment from the  
Ottawa First Responder Foundation via cheque or e-transfer no longer than 14 days after I provide the  
receipt of service rendered to the Foundation.

\_\_\_\_\_ date: \_\_\_\_\_  
(signature)