ATTESTATION OF THE RECOMMENDATION TO USE A MOTORIZED MOBILITY AID WHOSE WIDTH EXCEEDS 75 CM OR A WHEELCHAIR PROPELLED BY AN ELECTRIC MOTOR AND THAT IS OPERATED STANDING UP

I, ____, ____________________
(first and last names of professional) (number of licence to practise)

practising as a

- ☐ chiropractor;
- ☐ occupational therapist;
- ☐ specialized nurse practitioner;
- ☐ physician;
- ☐ physiotherapist;

recommend that

____, ____________________
(first and last names of patient) (date of birth)

- ☐ use a motorized mobility aid whose width exceeds 75 cm;
- ☐ use a wheelchair propelled by an electric motor and that is operated standing up.

The recommendation is

- ☐ for a temporary period, namely, until __________________________ (in the absence of an end date, the attestation is valid for five years);
- ☐ perpetual.

In _________________, this ______ day of ___________ 20_____,
(city or town)

____
(signature of health professional)

____
(name of institution or clinical site)

____
(telephone number)

____
(mailing address)

Except for the signature of the professional, this attestation must be completed in print or block letters.