

APPLICATION FOR NON-ELECTIVE MEDICAL/DENTAL
TREATMENT BENEFIT UNDER THE IPGH DIRECTIVE

At certain remote locations, employees of the Federal Government and their dependents are entitled to benefits outlined in the National Joint Council IPGH Directive. The Directive includes provisions for employees/dependents (section 3.1) to be reimbursed for expenses and leave necessary to obtain medical or dental treatment that is: a) not elective; and b) not available at the employee's headquarters (i.e. isolated post); and c) required without delay (i.e. within a reasonable period of time).

Part I – Personal Information

Patient's Family Name:	Patient's Given Name(s):
Employee's Family Name:	Employee's Given Name(s):
Community where employee works:	
Employee relationship to the patient:	

Part II – Medical/Dental Practitioner Referral (to be completed by the medical/dental practitioner – please initial all that apply)

<input type="checkbox"/>	I certify that I am the attending medical/dental practitioner for the patient named above.
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I certify that the patient requires treatment which is:

<input type="checkbox"/>	not elective
<input type="checkbox"/>	not available at the employee's headquarters (i.e. isolated post)
<input type="checkbox"/>	required without delay (i.e. within a reasonable period of time)

The nearest community where prescribed treatment is available is:

This treatment is for:

Referral Type			
<input type="checkbox"/>	Medical	<input type="checkbox"/>	Dental (please see below)

Medevac Required			
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

Type of Dental*			
<input type="checkbox"/>	A newborn infant afflicted with cleft lip(s) and palate.	<input type="checkbox"/>	A person involved in an accident involving broken jaw(s) or seriously damaged teeth.
<input type="checkbox"/>	A person having severely handicapping malocclusions causing severe masticatory dysfunction.	<input type="checkbox"/>	Non-cosmetic/Non-aesthetic

* Please note that orthodontic treatment that is aesthetic or cosmetic in nature, other than the above, is not covered under the IPGH Directive.

<input type="checkbox"/>	It is necessary for the person obtaining treatment to be escorted during the period of travel because (please check):
<input type="checkbox"/>	the patient is under the age of majority
<input type="checkbox"/>	the patient has a mental or physical disability of a nature such that she/he is not able to travel unassisted
<input type="checkbox"/>	other (explain) _____

Name of referring medical/dental practitioner (please print):	Initials of referring medical/dental practitioner:
Signature of referring medical/dental practitioner:	Date:

Part III – Employee statement* (to be completed by the employee)

<input type="checkbox"/>	I certify that I am not able to make alternate arrangements for the care of my dependants at the isolated post during my absence and therefore they must accompany me.
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I certify, to the best of my knowledge, that the information provided on this form is true.	
Employee signature:	Date:

*Please note that you will need to obtain confirmation from the treating facility as to the date that treatment was received.