

Instructions:

1. Please print.
2. Have Medical Professional describe the disability and sign form.
3. Send completed form to:
 1503 Fletcher Road or Email: crcsales.admin@sasktel.com
 Saskatoon SK
 S7M 5S5

Completed by Applicant

Name of Applicant _____ Date _____

Address _____ City/Town _____ Postal Code _____

Health and Services card number _____

Name of Billed Customer _____ Telephone Number _____

Cellular number _____

Name of Contact _____ Telephone number _____

Please check the service/equipment requested and have diagnosis completed by the appropriate person.
 (The Applicant is responsible for any charges related to the diagnosis.)

Sight

Doctor/CNIB Representative:	Speed Call 8	Speed Call 30
Directory assistance Exemption:	Landline Telephone	Cellular Telephone

Motion

Occupational Therapist/Doctor:	Speed Call 8	Speed Call 30
Directory assistance Exemption	Landline Telephone	Cellular Telephone

Hearing

Doctor/Audiologist:	Telewriter (TTY)	50% toll discount (TTY user only)	Signaling Unit (TTY user only)
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Speech

Doctor/Speech Therapist:	Telewriter (TTY)	50% toll discount
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Signature of billed Customer _____

Completed by:

Speech Pathologist	Audiologist	Doctor	Occupational Therapist	CNIB Representative
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Type and degree of disability (be specific) _____

I hereby certify that the applicant has the disability described which would prevent them from using a standard telephone, using the telephone directory, or recording a number for future use.

Speech Pathologist, Audiologist, Doctor, Occupational Therapist, CNIB Representative (Signature) _____

Date _____ Telephone number _____ Name _____

Completed by SaskTel

Service/equipment _____

SO number _____ SO due date _____ SR name _____ SR initials _____