SURGICAL TOURISM CANADA INC.

Healthcare without borders

Client Application

Name (print) ____

Date of Birth (day/month/year) __________________________

Street ___________________City __________________Province _____Postal code_________

Date ______________Signature of client ______________________Tel ___________________

What Type of STC service are you applying about, please specify?

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How will you be paying for STC services? Private pay _ ___Insurance Company._____

If applicable, Name of insurance company ____

Have you discussed this application with your attending physician? If yes please provide the following information:

Physician's Name (print) __________________________Telephone no: _________________

Street___________________City _________________Province _____Postal code___________

Is it appropriate for STC to contact your physician regarding your application? Yes ____No _____

Patient Consent

Name of Patient (print) ____

Date of Birth (day/month/year)______________Street_______City ____Province ____Postal Code________

I hereby authorize the release to Surgical Tourism Canada any information or records relevant to the

condition____for which I am seeking treatment

through STC.

Date (day/month/year)________________________Signature of patient ____________________________

Tel ___________________

When you have completed this form please fax it to 778-574-7253 or email to info@surgicaltourism.ca

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