Ontario

Ministry of Health

Assistive Devices Program (ADP)
5700 Yonge Street, 7th Floor
Toronto ON M2M 4K5
Tel: 416 327-8804
Toll-Free: 1 800 268-6021
Fax: 416 327-8192

Application for Equipment Listing
Wheelchairs, Positioning and Ambulation Aids

Note: All sections must be completed for each product.

Section 1 – Manufacturer

Name of Manufacturer

Address

Unit Number	Street Number	Street Name	PO Box

City/Town	Province/State	Postal Code

Country	Telephone Number

Section 2 – Distributor

Name of Distributor

Address

Unit Number	Street Number	Street Name	PO Box

City/Town	Province	Postal Code
	ON	

Contact Person

Name of Contact (Last Name, First Name)

Telephone Number ext.	Fax Number

Section 3 – Device

1. Name of device

2. Medical Device Establishment License (MDEL)

3. Type of device (please check appropriate boxes)

a. ☐Paediatric ☐Adult

b. ☐Wheelchair ☐Positioning device ☐Ambulation aid

4. Which ADP device category do you believe this product belongs in?

5. Was any formal testing done on the device?

☐Yes, include Prior Testing Forms

☐No, explain why

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6. Flammability standards

a) Does the upholstery and seating material used on the product meet flammability standards?

☐Yes, indicate standard(s)

☐No

b) For this product to be considered for listing by ADP, you must be prepared and willing to disclose these flammability test results, or lack thereof, at the request of potential consumers.

Do you agree to this?

☐Yes ☐No

7. Does the warranty meet the ADP minimum requirement (24 months)?

☐Yes

☐No, explain why

8. What is the maximum user weight restriction?

9. Does the Manufacturer/Distributor hold a minimum of $2 million liability insurance for the product in question?

☐Yes

☐No, explain why

10. List notable customizations that can be made and indicate who can make them.

		Manufacturer	Vendor	Clinician
a)				
b)				
c)				
d)				
e)				
f)				
g)				

11. Do you provide a training program for vendors to repair the device?

☐Yes

☐No, indicate how you ensure proper servicing of your product.

Section 4 – Certification and Signatures

I, as a signing officer of the manufacturer/distributor, certify that the above information is complete and true.

Name (Last name, First name)	Position
Signature	**Date (yyyy/mm/dd)**

Please return completed document to:

Assistive Devices Program
5700 Yonge Street, 7th floor
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