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 Funding of Changes/Modifications/New Options to ADP Approved Devices

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

Contact Person

Name of Contact

Telephone Number ext.	Fax Number

Section 3 – Device

1. Name of Device

2. Device Type

Device Code

3. List all the changes/modifications/new options for this device. Attach more details including diagrams if necessary.

4. Medical Device Establishment License (MDEL)

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5. Was any formal testing done on the device?

☐ Yes, include Prior Testing Disclosure form

☐ No, explain why

_____

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

☐ Yes

☐ No, explain why

_____

9. Do the changes/modifications/new options affect the user weight restriction?

☐ Yes, in what way? _____

☐ No

10. Does the owner's manual reflect these changes/modifications/new options?

☐ Yes, include a copy ☐ No

11. How do each of the changes/modifications/new options affect the following?

	Current Device	**Modified Device**
a) static stability (i.e., base of stability)		
b) dynamic stability (i.e., when executing sharp turns, when accelerating)		
c) efficiency of braking mechanisms		
d) energy consumption		
e) rolling resistance		
f) overall dimensions		
g) mass (weight)		
h) turning radius		
i) maximum speed		
j) acceleration and deceleration rates		

12. How do each of the changes/modifications/new options affect the following?

	Comments
a) safety	
b) obstacle climbing ability (e.g., curbs)	
c) electrical connections	
d) manual override feature	
e) structural quality	
f) function (e.g., ease of independent mobility)	
g) ergonomics (e.g., operating forces)	

Section 4 – Certification and Signatures

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

Last name	First name

Position

Signature	Date (yyyy/mm/dd)

Note: The device must continue to meet applicable ADP minimum criteria to remain listed.

Please return completed document to:
Assistive Devices Program
5700 Yonge Street, 7th floor
Toronto ON M2M 4K5