Ontario

Ministry of Health

Assistive Devices Program (ADP)
5700 Yonge Street, 7th Floor
Toronto ON M2M 4K5

Authorizer Application Attachment B

This form is to be used as a supplement to the Application for Authorizer Status. Use copies of this form to notify the Program of additional employment locations.

Section 1 – Applicant Information

Last Name	First Name	Middle Initial

Section 2 – Additional Employment Locations

If in private practice, this section must also include all companies who are currently employing the applicant's service.

Location 1

Address

Unit Number	Street Number	Street Name		
Lot/Concession/Rural Route	**City/Town**		**Province**	**Postal Code**
			ON	
Business Telephone Number	**Fax Telephone Number**	**Email Address**		

Location 2

Address

Unit Number	Street Number	Street Name		
Lot/Concession/Rural Route	**City/Town**		**Province**	**Postal Code**
			ON	
Business Telephone Number	**Fax Telephone Number**	**Email Address**		

Location 3

Address

Unit Number	Street Number	Street Name		
Lot/Concession/Rural Route	**City/Town**		**Province**	**Postal Code**
			ON	
Business Telephone Number	**Fax Telephone Number**	**Email Address**		

Location 4

Address

Unit Number	Street Number	Street Name		
Lot/Concession/Rural Route	**City/Town**		**Province**	**Postal Code**
			ON	
Business Telephone Number	**Fax Telephone Number**	**Email Address**		

Section 3 – Confirmation

The information provided on this form is true, correct and complete to the best of my knowledge.

Signature	Date (yyyy/mm/dd)

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