

MEDICAL ASSISTANCE IN DYING TRAVEL AND TRAINING ASSISTANCE PROGRAM (MAIDTTAP) VISITING MENTOR FUNDING REQUEST

HLTH 1643 2024/03/26

HOW TO SUBMIT THIS REQUEST

This completed form with any attachments must be submitted via the secure upload tool located at: www.gov.bc.ca/submit-rural-practice-programs

LOCAL RSA PHYSICIAN COMMUNITY:			VISITING MENTOR COMMUNITY:				
MAiD Service	Name of Physician			Practitioner # f Physician	Planned Date For Visit (YYYY / MM / DD)	Total Estimated Travel Expenses	Total Estimated Travel Time Honorarium Cost
Visiting Mentor							
Local Provider							
Information for Funding (attach additional information as necessary)							
Indicate if the one-way travel distance for nearest available MAiD Visiting Mentor is at least 35km.							
Indicate whether a local physician has attended a provision with any MAiDTTAP provider in the past.							
3. Indicate, if any, how many times the local physician has provided MAiD; either with a Visiting Mentor or independently.							
Coordinator, MAiD Care Coordination Service (MCCS)			Email Address			Phone Number	
Health Authority		Mailing Address	I				

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Total Approved Travel Expenses	Total Approved Travel Time				