

I hereby declare that the patient indicated below does not have any private insurance and qualifies for OHIP+ coverage.

(t:
Name of guardia	an (if applicable):
Signature of pa	tient/guardian
Rx/Tx #:	Date of claim adjudication:
ONTARIO PHARMACISTS ASSOCIATION Advocating Excellence in Practice and Care	
PHARMACISTS Association Advocating Excellence in Practice and Care I hereby decl below does r	are that the patient indicated not have any private insurance for OHIP+ coverage.
PHARMACISTS ASSOCIATION Advocating Excellence in Practice and Care I hereby decl below does r	not have any private insurance for OHIP+ coverage.
Pharmacists association Advocating Excellence in Practice and Cure I hereby decl below does r and qualifies	not have any private insurance for OHIP+ coverage.
PHARMACISTS ASSOCIATION Advocating Excellence in Practice and Care I hereby decl below does r and qualifies Name of patient	not have any private insurance for OHIP+ coverage.
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I hereby declare that the patient indicated below does not have any private insurance and qualifies for OHIP+ coverage.

Name of patient:	
Name of guardian	(if applicable):
Signature of patier	nt/guardian
Rx/Tx #:	Date of claim adjudication:
ONTARIO PHARMACISTS ASSOCIATION Advocating Excellence in Practice and Care	
below does no	e that the patient indicated t have any private insurance or OHIP+ coverage.
Name of patient:	
Name of guardian	(if applicable)
(gaaratan	(парисано).
Signature of patier	nt/guardian
Rx/Tx #:	Date of claim adjudication: