Rainbow Baby Wagon Special Needs Discount Application Form

This form is to be completed by the patient's medical care provider.
(Physician, therapist, medical social worker, or child specialist)

Physician Information:

Name:_____ Title:_____

MINC:_____ Province:_____

Hospital or Medical Institution Name:_____

Patient Information:

Patient's Medical Diagnosis:_____

Please describe how a stroller wagon will benefit the patient emotionally, physically, psychologically, and/or
socially:_____
_____
_____
_____
_____
_____

Will our stroller wagon be a part of the patient's medical treatment plan? Yes / No

Legal Guardian's Signature: _____ Print Name:_____

Medical Care Provider Signature: _____ Print Name:_____

Date:_____