

Instructions:

Please print and send this completed form to:

Mail:

SaskTel
4th Floor - 140 1st Ave. North
Saskatoon, SK S7K 1W8

Email:

crcsales.admin@sasktel.com

Completed by Applicant

Name of Applicant _____ Date _____

Address _____ City/Town _____ Postal Code _____

Health Card Number _____

Name of Billed Customer _____ Phone Number _____

Cell Phone Number _____

Name of Contact _____ Phone Number _____

Please check the service/equipment requested and have diagnosis completed by the appropriate person.
(The Applicant is responsible for any charges related to the diagnosis.)

Sight

Speed Call 8

Speed Call 30

Landline Phone

Cell Phone

Motion

Speed Call 8

Speed Call 30

Landline Phone

Cell Phone

Hearing

Doctor/Audiologist: Telewriter (TTY) 50% Toll Discount (TTY user only) Signaling Unit (TTY user only)

Speech

Doctor/Speech
Therapist: Telewriter (TTY) 50% Toll Discount

Signature of Billed Customer _____

Completed by SaskTel

Service/equipment _____

SO number _____ SO due date _____ SR name _____ SR initials _____