

Instructions:

1. Please print.
2. Have Medical Professional describe the disability and sign form.
3. Send completed form to:
1503 Fletcher Road
Saskatoon SK
S7M 5S5
or 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

Doctor/CNIB Representative:

Speed Call 8

Speed Call 30

Directory assistance Exemption:

Landline Phone

Cell Phone

Motion

Occupational Therapist/Doctor:

Speed Call 8

Speed Call 30

Directory assistance Exemption

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 _____