

**TRAVEL APPLICATION**

FAMILY INFORMATION	
Patient Name:	Date of Birth:
Parent Name(s):	
Email Address:	
Address:	
Telephone:	Referred By:
Diagnosis:	
Oncologist/Primary Nurse or Social Worker (if applicable):	
TRAVEL INFORMATION	
Travel To: Alberta Children's Hospital 2888 Shaganappi Trail NW, Calgary AB T3B 6A8	Other Location:
KM/ Round Trip:	
2026 KM rate set by the CRA is 34 cents per KM. Travel can be calculated by the Detailed Method or Simplified Method below. *If you choose the detailed method please provide all receipts for the month. *If you choose the simplified method, follow below:	
<p><b>Simplified Method</b></p> <p><b>Month of Travel:</b></p> <p>Trips/Week: _____ x _____ KM / Each x 20 Cents (Up to \$500/yr) = \$ _____</p> <p><b>Meal Coverage (max 2pp):</b></p> <p>Meals Required / Trip (Patient): _____ x _____ \$17 / Meal to Max of \$51 / Day = \$ _____</p> <p>Meals Required / Trip (Attendant): _____ x _____ \$17 / Meal to Max of \$51 / Day = \$ _____</p> <p>Total Travel &amp; Meal Expenses: \$ _____ For the Month of: _____</p> <p>Payment Made to: _____ Date: _____</p>	

**VERIFICATION:** *By signing you are consenting to release information to Believe in the Gold*

I (Parent/Guardian) verify this information to be true: \_\_\_\_\_  
*Signature* *Date*

Nurse/Social Worker/Oncologist: \_\_\_\_\_  
*Signature* *Date*

**NOTE: To be approved all fields must be filled out.**

**APPROVAL**

Believe in the Gold: \_\_\_\_\_  
*Signature* *Date*