childhood cancer Believe® IN THE GOLD

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:

Simplified Method
Month of Travel:
Trips/Week: ________________ x ______________ KM / Each x 34 Cents (Up to $500/yr) = $ __________

Meal Coverage (max 2pp):

Meals Required / Trip (Patient): ___________ x _____ $23 / Meal to Max of $69 / Day = $________________

Meals Required / Trip (Attendant): _________ x _____ $23 / Meal to Max of $69 / Day = $________________

Total Travel & Meal Expenses: $ _________________ For the Month of: ______________________________

Payment Made to: _____________________________Date: _______________________________________

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*