CEP

ADP Individual Authorizer Quote Request Form

Fax: 416.698.3793
Email: sales@mail.cepp.org

Date:	**ADP Auth. Number:**
IA Name:	
IA Address:	
Phone:	**Fax:**
Email:	
Ship To:	**Client:** ☐ **Clinic:** ☐

Client Name (First):	
Client Name (Last):	
Care of Name:	
Client Address:	
City:	**Province:**
Postal Code:	
Home Phone:	
Sex:	**Male:** ☐ **Female:** ☐
Health Card #:	
Date of Birth (mm/dd/yyyy):	
Diagnosis:	
Status:	**ADP (75/25):** ☐ **MCSS:** ☐

ADP Catalog#	Device Description

Comment:

** Note - Equipment purchased is shipped with an invoice that must be signed by the client/family and returned in a self addressed stamped envelope (included). Please advise the client/family of this important duty.* ***Failure to receive a signed invoice will result in the Individual Authorizer being contacted and requested to follow up with the client/family.***