# Company Name

# Your logo here

## Recent diagnostic test(s) have revealed that I/we believe you would benefit from [insert clinical intervention, e.g., oxygen, CPAP, etc.]. Below is a list all of the [insert intervention, e.g., oxygen/CPAP/BiPAP] vendors within a \_\_\_\_km radius where you can purchase this equipment/service.

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| --- |
| LOCAL VENDORS (IN ALPHABETICAL ORDER) |
|  Company Name: |      | Address:       | Phone:     |
| Company Name: |      | Address:       | Phone:     |
| Company Name: |      | Address:       | Phone:     |
| Company Name: |      | Address:       | Phone:     |
| Company Name: |      | Address:       | Phone:     |
| Company Name: |      | Address:       | Phone:     |
|  |
| CONFLICT OF INTEREST DISCLOSURE |
| Please be aware of a perceived/conflict of interest, in that [**fully describe details of the perceived/conflict of interest, for example:** [COMPANY NAME] leases space to / has an agreement with [VENDOR NAME], and employees of [COMPANY NAME] may also work at [VENDOR NAME]. Additionally, the remuneration of certain [COMPANY NAME] employees is directly related to the number of clients who purchase equipment from [VENDOR NAME]]. Please note that there are other vendors available to you. Local ones are listed alphabetically above. You are not required to deal with [VENDOR NAME]. You have the right to deal with any company you prefer, and your treatment by [COMPANY NAME] will not suffer or change in any manner. |
| Signatures |
| **🞐 I have read and understand the above statements, and clarified any questions with the staff of the [COMPANY NAME].****🞐 I have been informed that I may be eligible for a subsidy by a third party, e.g., Assistive Devices Program, Veterans Affairs, private insurers, etc.** |
| Patient/Substitute Name PRINTED: |  | Date: |  |
| Patient/SubstituteSIGNATURE: |  |  |  |
| Employee Signature: |  | Date: |  |