# 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.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 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/Substitute  SIGNATURE: | |  | |  |  | |
| Employee Signature: | |  | | Date: |  | |