Drivers Medical Examination Reimbursement (DMER)

Patient Information

Last Name | Middle Name | First Name

Date of Birth (YYYY/MON/DD) | MCP Number

Mailing Address | City | Province | Postal Code

Phone | Email:

Medical Exam Performed by | Date (YYYY/MON/DD)

Amount Paid | Receipt Number

Personal information on this form is being collected for the purpose of evaluating DMER applications. This information is collected under the authority of section 61(c) of the Access to Information and Protection of Privacy Act, 2015. By signing this form you have consented to the collection of information by the Medical Services Division of the Department of Health and Community Services for the purpose of evaluating DMER. If you have any questions about the collection, use or disclosure of your personal information, contact us at driversmedicals@gov.nl.ca

☐ **I certify that all information given on this application is complete and true to the best of my knowledge.**

Applicant Signature (You may sign digitally; or print, sign, and scan) | Date (YYYY/MON/DD)

Verbal Confirmation | Date (YYYY/MON/DD)

Instructions:

- Fill in the patient's information
- Attach a copy of your payment receipt
- Email or mail out the form and the receipt to:

Email Address: driversmedicals@gov.nl.ca

Toll Free Number: 1-833-864-0223

Mailing Address:
Drivers Medical Examination Reimbursement
Department of Health and Community Services
Medical Services Division
1st Floor, Confederation Complex
P.O. Box 8700
St. John's, NL A1B 4J6

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