I, _____, _____, member of
(first and last names of the professional) (number of licence to practise)

- ☐ the Ordre professionnel des chiropraticiens du Québec;
- ☐ the Ordre professionnel des ergothérapeutes du Québec;
- ☐ the Ordre professionnel des médecins du Québec;

prescribes to _____, _____,
(first and last names of the patient) (date of birth)

- ☐ the use of a motorized mobility aid whose width exceeds 75 centimetres;
- ☐ the use of a wheelchair propelled by an electric motor and that is operated standing up.

This prescription is valid until _____.
(In the absence of an end date, the prescription is valid for two years.)

In _____, this _____ day of _____ 20_____,
(city or town)

_____
(signature of health professional)

_____
(name of institution or clinical site)

_____
(telephone number)

_____
(mailing address)

[1] Except for the signature of the professional, this prescription must be completed in print or block letters.