

CONFIRMATION FROM DOCTOR OR NURSE FORM 3

From:	To be filled out by a Health Care Official (Doctor or Nurse)
Address:	
Phone #:	
Email:	
Date:	
TO: Qikiqtani Inuit Association Community Liaison Officer 200-922 Niaqunngusiariaq St, NU, XOA 3 Phone: (867) 975-8400 Toll Free: 1-800-6 Email: Griefandbereavement@qia.ca Website: www.qia.ca	
Dear <u>Qikiqtani Inuit Association</u> ,	
This Letter is to inform you that	is facing imminent
death. He / She is a resident of	. He / She currently located
athospital.	
His / Her NTI Enrolment Number is	<u>.</u>
Please contact me at phone number	or I can be contacted
by email at	if you require any other information or have
any questions.	
Sincerely,	
Print Name:	Position:
Signature:	<u></u>