



**CONFIRMATION FROM
DOCTOR OR NURSE
FORM 3**

To be filled out by a Health Care
Official (Doctor or Nurse)

From: _____
Address: _____
Phone #: _____
Email: _____
Date: _____

TO:
Qikiqtani Inuit Association
Community Liaison Officer
200-922 Niaqunngusiariaq St, NU, X0A 3H0
Phone: (867) 975-8400 Toll Free: 1-800-667-2742
Email: Griefandbereavement@qia.ca
Website: www.qia.ca

Dear Qikiqtani Inuit Association,

This Letter is to inform you that _____ is facing imminent
death. He / She is a resident of _____. He / She currently located
at _____ hospital.
His / Her NTI Enrolment Number is _____.

Please contact me at phone number _____ or I can be contacted
by email if you require any other information or have any questions.

Sincerely,

Print Name: _____ Position: _____