Declaration Form:
Reimbursement of Loss of Work-Related Income

PRINT CLEAR FORM

Name:

(person requesting reimbursement)

Address:

Start Date	End Date	Hours of Loss of Work-Related Income	Amount Requested	Amount Reimbursed

Total Hours:	
Total Amount Requested:	$ 0.00
Total Amount Reimbursed:	$ 0.00
Date of Reimbursement:	

	Agree	Disagree
The loss of work-related income to be reimbursed has not been paid to me (the person requesting reimbursement) by any other source, in full or in part.	☐	☐
All of the information contained herein is accurate, complete, and supported by the required evidence to the best of my (the person requesting reimbursement's) knowledge.	☐	☐

Signature:

(person requesting reimbursement)

Date:

Signature:

(person who reimburses)

Date:

This declaration form was prepared by Health Canada as a sample. It can be used to request and declare reimbursement for loss of work-related income or as guidance for the required elements.