Manitoba
Family Services and Consumer Affairs

# Statement of Account

| DISTRICT OFFICE | COUNSELLOR |
|---|---|
| ADDRESS | |
| | |
| NAME OF CLIENT | |

For payment of services requested by Employment and Income Assistance please complete and return this form along with the completed Medical Assesment form to the Employment and Income Assistance District Office addressed above. (Please print.)

Dr. ______________________ Date ______________

Address ______________________
In account with PROVINCE OF MANITOBA

Name of Patient ______________________

Address ______________________

______________________

Date of Examination ______________________

Fee of examination $ __________

Fee for report $ __________

______________________ M.D.
Signature of Examining Physician

TOTAL $ __________

FOR OFFICE USE ONLY

CENTRAL ACCOUNTS

DATA ENTRY BY: __________

Approved for Payment

______________________
Counsellor

______________________
Date

Part 1 - White - Central Accounts    Part 2 - Yellow - Central Accounts    Part 3 - Pink - File Copy

MG-6013 (Rev. 04/10)

Sample