The information on this form is collected under the authority of the Alberta *Health Information Act* and will be used only for the purpose of responding to your request for a COVID-19 result which is required for international travel.

**Submit completed form by:**

* Email to [APLCIT@albertaprecisionlabs.ca](mailto:APLCIT@albertaprecisionlabs.ca)
* Fax to 403-770-3701

**Fee:**

* **$25** online payment required
* Go to **AHS website > Information for > Patients & Families > Quick Reference > Make a Payment** or <https://www.albertahealthservices.ca/pay/Page11918.aspx>
* Routing number: **3003**
* Invoice number: **2020-001**

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| **Requestor Information** | Mr.  Mrs.  Dr.  Ms.  Miss | | Last name | | First name | |
| Mailing address | | | | | |
| City or town | | | Province | | Postal code |
| Telephone (business) | | Telephone (home) | Email address | | |
|  | Relationship to the patient/traveler:  Self  Other:  **Parent requestor:** initial here \_\_\_\_\_\_\_ to confirm there are no custody issues or court guardianship orders for the child. | | | | | |
| **Patient/Traveler**  **Information** | Last name  Same as above | | | First name  Same as above | | |
| Date of birth | | | Personal Health Number | | |
| **Request for COVID-19 result for international travel** | Date of collection |  | | | | |
| Date of travel |  | | | | |
| Destination | International  Domestic | | | | |
| **Delivery** | Results are routinely provided by email.  I require an alternate delivery method  **By signing below the patient agrees to have their COVID-19 result emailed to the address indicated above.** | | | | | |
| **Patient Signature** (Required) | Signature Date | | | | | |

***For authorized office use only:***

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| Date received | ID confirmed:  Yes  N/A | Request number |
| Date released | Signature of recipient | Records released by |