



Mary Pack Arthritis Program
895 West 10th Ave
Vancouver, BC V5Z 1L7

TRAVEL LETTER

Date: _____

To Whom It May Concern:

Regarding: Name: _____

D.O.B. _____

Diagnosis: _____

Physician: _____

Medication prescribed: _____

____ Please administer the above medication as prescribed for this person.

____ Needs to carry syringes and needles to administer the above medication.

Thank you for your service,

Title: _____