TRANSPLANT QUÉBEC

Loss Income Certificate

Reimbursement Program for Living Donors (RPLD)

This form must be completed by the transplant centre in block letters.

Family name of donor : _____

Given name of donor : _____

Date of birth of donor : _____ - _____ - _____
yyyy *mm* *dd*

Health insuance number of donor : _____

Name of transplant centre : _____

Date of surgery : _____ - _____ - _____ kidney ☐ liver ☐
yyyy *mm* *dd*

In my opinion, the above-mentionned donor will not be able to return to work until: _____ - _____ - _____
yyyy *mm* *dd*

Comments :

_____

_____

_____

_____

_____

_____

_____ _____ _____ - _____ - _____
(Name of surgeon or transplant coordinator) *(Signature of surgeaon or transplant coordinator)* *yyyy* *mm* *dd*

(in block letters)