



Millbrook Non-Band Member Health Services
 Application Form
 P.O. Box 634, Truro, N.S. B2N 5E5

Office use only: Received this _____ day of _____ A. D. 2024/25

Millbrook Administration: _____

Applicant Name: _____

Are you a member of another band? If so, Band #: _____ Senior (65+): Yes / No

Health Card #: _____ E-mail: _____

Phone #: _____ How long have you lived in Millbrook? _____

Cellphone # _____ Date of Birth: _____

Home Address: _____

Are you currently living in the Millbrook First Nation Community or are you related to or the spouse of a Millbrook Band Member? (Millbrook & Satellite communities) Please explain:

Do you have a doctor? If yes, why do you want to change to Millbrook First Nation?

Name of Millbrook person you're connected to:

Band #: _____ Relationship: _____

Phone #: _____ Senior (65+): Yes / No

E-mail: _____

Do you have Children together? Yes / No

Who has primary custody of the children? _____

Are you willing to make the Millbrook First Nation doctor your only doctor? Yes / No

We will require past medical history, your medication list and your immunization record. You are responsible for providing that information.

Signature of Applicant

Date

Signature of Millbrook Band Member / Witness

Date

Office use only: Approved () Not Approved ()

Health Director: _____