

American Organ Transplant Association - Request for Travel Assistance

Return Via Fax 218-617-4274 or for questions Call 713-344-2402

TO BE COMPLETED BY SOCIAL WORKER/HOSPITAL/FACILITY

TRAVELERS/PATIENT INFORMATION

Patient Name _____ M () F () Age _____

Address _____ City _____ ST _____ Zip _____

Home Phone _____ Mobile Phone _____ Email _____

Transplant Type _____ Travel Reason: ___ Evaluation ___ Transplant ___ Follow-Up

Traveler 1 _____ Relationship to Patient _____

Home Phone _____ Mobile Phone _____ Email _____

*Voucher Number: _____ Date Issued: _____

Traveler 2 _____ Relationship to Patient _____

Home Phone _____ Mobile Phone _____ Email _____

*Voucher Number: _____ Date Issued: _____

*To be completed by AOTA representative/volunteer

FACILITY INFORMATION

Requesting Facility _____

Facility Address _____

Person Making Request _____ Title _____

Phone _____ Fax _____ Email _____

TRAVEL INFORMATION

Requested Travel: () One Way () Round Trip Initial Request? () Yes or () No

Departure City _____ Departure Date _____

Preferred Time for Departure: Morning Afternoon Evening Specific Time: _____

Confirmed Time Departing: _____ Arriving: _____

Destination City _____ Return Date _____

Preferred Time for Departure: Morning Afternoon Evening Specific Time: _____

Confirmed Time Departing: _____ Arriving: _____

Describe Need or Enclose Letter Outlining Transplant Status & Justification for Additional Travelers:

For Internal Use Only:

AOTA Representative/Volunteer _____ Date: _____

Notified _____ Date _____ By Email with Read Receipt By Phone: Voice Mail Spoke

Notified _____ Date _____ By Email with Read Receipt By Phone: Voice Mail Spoke

Notes: _____

Greyhound Bus Lines: 877-801-1569