British Columbia & Yukon Branch
200 – 4940 Canada Way
Burnaby, BC V5G 4K6
Ph: 604 736 9775 | 1 800 5678112
Fax: 604 736 9703 |1 800 667 8871
kidney.ca

LIVING ORGAN DONOR EXPENSE REIMBURSEMENT PROGRAM (LODERP)

Income and Benefit Verification Form

CONSENT AND AUTHORIZATION – To be completed by the claimant

I,_____, the undersigned, understand that in making an application to The Kidney Foundation of Canada, BC & Yukon Branch (KFoC-BCY), I am required to provide certain information to the Foundation. My signature below authorizes my employer to release the required information to the Foundation. I acknowledge that the information that I have provided on this form is accurate and complete to the best of my knowledge.

I understand that the personal information provided in this application will be used only for establishing my eligibility for expense reimbursement from The Kidney Foundation of Canada, BC & Yukon Branch and for compilation of demographic and statistical information. I further understand that no personally identifiable information will be disclosed in the reporting of any demographic or statistical information.

If you have concerns about how KFoC-BCY Branch manages your personal information please visit www.kidney.ca/kidney-foundation-policies/privacy-policy or call the Privacy Officer at 604-736-9775 or 1-800-567-8871.

OFFICE USE ONLY

Date of Birth: _____

Signature:_____Date: _____

- Page 1 of this form needs to be completed by the Claimant, saved and emailed to heather.johnson@kidney.ca or faxed to 1-800-667-8871.
- Page 2 of this form needs to be completed by your Employer, saved and emailed to heather.johnson@kidney.ca or faxed to 1-800-667-8871.

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Income and Benefit Verification Form

EMPLOYER INFORMATION – To be completed by the employer

Please complete the information below and return the completed form to The Kidney Foundation of Canada, BC &Yukon Branch, by saving and emailing to heather.johnson@kidney.ca or faxing to 1-800-667-8871.

Employer/Company Name: _____

Tel: _____ Email: _____

EMPLOYEE INFORMATION – To be completed by the Employer

Employee (Claimant) Name: _____

How long has the employee/claimant worked for your company? _____

What is his/her average weekly NET pay (over the past six months)? _____

Will this employee qualify for Employment Insurance Sickness Benefits? ◯ Yes ◯ No ◯ Uncertain

BENEFIT VERIFICATION – To be completed by the Employer

Is this employee entitled to paid time off while recovering from the living organ donor surgery?

◯ Yes ◯ No ◯ Partially (Please explain): _____

What salary replacement and benefits are available to this employee during their time off work for living donor surgery recovery?

☐ Paid Sick Time (If yes, for how long?) _____

☐ Paid Leave of Absence (If yes, for how long?) _____

☐ Short Term Disability (If yes, what is the waiting period?) _____

☐ What will be the amount of STD payments weekly? _____

☐ Other (Please specify): _____