PROVISION OF TRANSPORTATION SERVICE FOR PATIENT’S DIALYSIS SESSION

PRICE SCHEDULE

1. Price Schedule for Medical Transport Service

VALIDITY OF QUOTE: Two Years

<table>
<thead>
<tr>
<th>Ambulance</th>
<th>Unit Price (exclusive of GST)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single Trip</td>
<td></td>
</tr>
<tr>
<td>Round Trip</td>
<td></td>
</tr>
<tr>
<td>Adhoc Trip</td>
<td></td>
</tr>
</tbody>
</table>

*Note: The price quoted should be inclusive of patient’s weight, time, location, public holiday, usage of medical equipment etc. There should be no further change in charges. Adhoc services are unscheduled services that are being requested for patients that do not have scheduled pick ups with the Vendor.*

The Vendors are requested to provide the following additional information:

1. Number of medical transport vehicle allocated: __________
2. Number of medical transport vehicle currently owned: __________
3. Policy on cut off service for no payment received from patient: __________________________
4. Does your company provide Dialysis Escort Service to patient: YES / NO (please circle)
   *Note: Dialysis Escort Service is a chaperon service whereby the Dialysis Escort would accompany patient from home to the appointed dialysis centre or vice versa.*

ACCEPTED BY

AUTHORISED SIGNATURE :

SIGNATORY’S NAME :

SIGNATORY’S DESIGNATION :

CONTACT NO. :

VENDOR’S NAME :

VENDOR’S STAMP :
PROVISION OF TRANSPORTATION SERVICE FOR PATIENT’S DIALYSIS SESSION

PRICE SCHEDULE

2. Price Schedule for Wheelchair Accessible Transport Service

VALIDITY OF QUOTE: Two Years

<table>
<thead>
<tr>
<th>Wheelchair Accessible Transport Service</th>
<th>Unit Price (exclusive of GST)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single Trip</td>
<td></td>
</tr>
<tr>
<td>Round Trip</td>
<td></td>
</tr>
<tr>
<td>Adhoc Trip</td>
<td></td>
</tr>
</tbody>
</table>

**Note:** The price quoted should be inclusive of time, location, public holiday etc. There should be no further change in charges. Adhoc services are unscheduled services that are being requested for patients that do not have scheduled pick ups with the Vendor.

The Vendors are requested to provide the following additional information:

1. Number of wheelchair accessible vehicle(s) allocated: __________
2. Number of wheelchair accessible vehicle(s) currently owned: __________
3. Number of wheelchairs the vehicle can accommodate: __________
4. Policy on cut off service for no payment received from patient: ______________________
5. Does your company provide Dialysis Escort Service to patient: YES / NO (please circle)

**Note:** Dialysis Escort Service is a chaperon service whereby the Dialysis Escort would accompany patient from home to the appointed dialysis centre or vice versa.

**ACCEPTED BY**

**AUTHORISED SIGNATURE :**

______________________________

**SIGNATORY’S NAME :**

______________________________

**SIGNATORY’S DESIGNATION :**

______________________________

**CONTACT NO. :**

______________________________

**VENDOR’S NAME :**

______________________________

**VENDOR’S STAMP :**

______________________________