Baxter

HOME PATIENT INTERNATIONAL TRAVEL DECLARATION

I acknowledge that I assume full responsibility for ensuring that when I travel, I will take with me all required dialysis products not provided by Baxter, such as ancillary products and non-Baxter products, as such will not be supplied by Baxter.

I fully acknowledge that Baxter is not responsible for any costs or fees if my travel plans are canceled or delayed for any reason (including without limitation government-imposed travel restrictions). For further clarity, in the event my travel is canceled or delayed, I recognize that I will not be entitled to any refund or reimbursement from Baxter.

I further acknowledge that:

1. I may not receive treatment "free of charge" from dialysis clinics or hospital institutions when traveling abroad, and that I will be fully responsible for any fees associated with such visits.
2. I am responsible to purchase transformers or power adapters for my destinations. These are not provided by Baxter and are therefore my responsibility.
3. I am fully responsible for any additional costs incurred, such as custom clearance fees, payment of any local duties or taxes on PD fluids and consumables, storage fees, returns and proper disposal of excess product. These fees are not Baxter associated; and are solely the responsibility of the patient travelling. Baxter is unable to advise on what these costs may be, however patients must be prepared to pay these fees as required on site.
4. I should take with me an appropriate quantity of dialysis solutions and supplies for the length of my trip in the event of a delay in the delivery or a delivery interruption for such Baxter-supplied products.

I have discussed my travel plans with my Dialysis Unit and Physician or Nurse and obtained written approval for my international travel.

Destination: **Travel Dates:**

Patient Name (please print):	
Patient Signature:	
Date:	

Patient is unable to sign form and I *(insert full name)* _____

At *(provide PD clinic name)* _____ have reviewed the

complete form and have obtained verbal consent from the patient.

HOSPITAL/CLINIC APPROVAL FOR INTERNATIONAL TRAVEL

PD patient should obtain their PD Physician or PD Nurse signature before returning this to Baxter

Hospital/Clinic Name:	
PD Physician or PD Nurse Signature:	
PD Physician or PD Nurse Print Name:	
Title:	
Date:	