Ontario

Ministry of Health

Application for Rehabilitation Incentive Grant

Please return signed copies to:
Primary Health Care Branch
Northern Health Programs
Fax: 705-564-7493
Email: NHP@ontario.ca

Please Note: The Ministry of Health retains the right to accept or not the application of any applicant for this program. For the applicant to be eligible to receive the incentive grant, this application must be approved by the Ministry of Health before the applicant establishes practice in the area designated as underserviced.

Section 1 - Personal Information

Last Name	First Name	Middle Initial

Present Address

Unit Number	Street Number	Street Name	PO Box

City/Town	Province	Postal Code

Telephone Number	Email Address

What is your immigration status in Canada?

☐Canadian Citizen ☐Permanent Resident ☐Other ▶

University	Graduation Date (yyyy/mm/dd)

Registration Number	Have you ever received an Incentive Grant? ☐Yes ☐No	Year

☐Audiology ☐Chiropody ☐Occupational Therapy ☐Physiotherapy ☐Speech-Language Pathology

Section 2 - Consent

Pursuant to the *Freedom of Information Act*

The Ministry of Health is authorized to collect the personal information requested in this form for the purpose of properly administering the Ministry's Rehabilitation Incentive Grants under subsection 6(1) paragraph 4 or clause 6(2)(b) of the *Ministry of Health and Long-Term Care Act*, R.S.O. 1990, c. M. 26. The personal information will be used to assess, verify and monitor eligibility for payment of a grant. For information about this collection, please contact the Northern Health Programs at 705-564-7280, toll free at 1-866-727-9959 or via email at NHP@ontario.ca.

I agree to cooperate fully with the Ministry of Health, or its agents, in any evaluation of the program by the Branch. Furthermore, I consent to the disclosure of my personal information, contained in any Ministry of Health files pertaining to the Northern Health Programs, to the Branch or its agents for the purpose of evaluating the Program, and to the agents of designated underserviced communities for the purpose of recruitment.

I, _____ , undersigned do hereby apply to the Ministry of Health of Ontario
First Name, Last Name

for an Incentive Grant to work full-time in an approved position in a Ministry of Health program serving an underserviced area.

The following documents are also required:

1. Signed acceptance of job offer and confirmation of starting date;
2. Copy of Ontario Certificate of Registration;
3. Imprinted blank void cheque.

Name	Signature	Date (yyyy/mm/dd)

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