Ontario

Consent and Capacity Board

Form A - Application to the Board to Review a Finding of Incapacity under Subsection 32(1), 50(1) or 65(1) of the *Health Care Consent Act.*

Section 1- Applicant (Patient/Resident)

Last Name			First Name	
Unit No.	Street No.	Street Name		PO Box
City/Town			Province	Postal Code
Telephone No. (including area code)	Fax No.	Email Address		

Section 2 - Application Type

I apply to the Board for a review of:

☐ a health practitioner's finding that I am incapable of consenting to my treatment

Specify:

☐ an evaluator's finding that I am incapable of consenting to my admission to a Long Term Care Home

☐ an evaluator's finding that I am incapable of consenting to receiving personal assistance services in a Long Term Care or Retirement Home

Section 3 - Person Who Made the Finding of Incapacity

Note: An application may only be made if a health practitioner or evaluator has made a relevant finding of incapacity.

Last Name			First Name	
Unit No.	Street No.	Street Name		PO Box
City/Town			Province	Postal Code
Telephone No. (including area code)	Fax No.	Email Address		

Section 4 - Health Practitioner Who Proposed the Treatment

If this application refers to **treatment**, provide the contact information about the person proposing treatment.

☐ Same as Section 3

Last Name			First Name	
Unit No.	Street No.	Street Name		PO Box
City/Town			Province	Postal Code
Telephone No. (including area code)	Fax No.	Email Address		

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Section 5 - Person Responsible for Authorizing Admission to Long-Term Care

If this application refers to **admission to long term care**, provide the contact information about the person responsible for authorizing admissions to the facility. This will usually be a person from the Local Health Integration Network.

☐ Same as Section 3

Last Name			First Name	
Unit No.	Street No.	Street Name		PO Box
City/Town			Province	Postal Code
Telephone No. (including area code)	Fax No.		Email Address	

Section 6 - Person Responsible for Providing a Personal Assistance Service

If this application refers to a **personal assistance service**, this may be the person or organization that provides the service.

☐ Same as Section 3

Last Name			First Name	
Unit No.	Street No.	Street Name		PO Box
City/Town			Province	Postal Code
Telephone No. (including area code)	Fax No.		Email Address	

Section 7 - Information About the Facility

Are you currently an in-patient or resident at a health or residential facility

☐ Yes, provide information about the facility ☐ No

Name of Facility			Ward	
Unit No.	Street No.	Street Name		PO Box
City/Town			Province	Postal Code
Contact Name (First Name, Last Name)		Telephone No. (including area code)		Fax No.

Section 8 - Person Who Will Represent the Applicant at the Hearing (e.g. lawyer)

Last Name			First Name	
Unit No.	Street No.	Street Name		PO Box
City/Town			Province	Postal Code
Telephone No. (including area code)	Fax No.		Email Address	

Section 9 - Other Information That Will Assist Us in Arranging the Hearing

Interpreter Required

☐ Yes ☐ No

Language

Accommodation required

☐Yes ☐No

Specify

Other Information

Date of Application (yyyy/mm/dd)

Collection of this information is for the purpose of conducting a proceeding before this Board. It is collected/used for this purpose under the authority of subsection 32(1) / 50(1) / 65(1) of the *Health Care Consent Act*. For information about collection practices, contact the Board. Fax completed application to the Board at 1-866-777-7273 or send by email to ccb@ontario.ca. For assistance, call: 1-866-777-7391.