Ontario

Consent and Capacity Board

Form B - Application to the Board to Appoint a Representative under Subsection 33(1), 51(1) or 66(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 to have a representative appointed to give or refuse consent on my behalf. This application is made with respect to:

☐ 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 - Proposed Representative

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 - 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 5 - Health Practitioner Who Proposed the Treatment

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

☐ Same as Section 4

Last Name	First Name

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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 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 4

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 - 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 4

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 8 - 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 9 - List Spouse, Partner, Parents, Siblings and Children of Patient/Resident

WARNING: All persons in the required categories together with correct and complete contact information must be listed unless you are unable to do so and have so indicated below*. If the Patient/Resident is under 18 years old, you must also list any agency or person legally authorized to make treatment/admission/personal assistance decisions on their behalf. Intentional omissions or misinformation may result in a cost award against you, dismissal of your application or sanctions.

Last Name	First Name	Relationship

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

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

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

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

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

If further room is required, check here ☐ **and add another page.**

***If you are unable to provide a complete and accurate list, please explain (attach a separate page if necessary):**

Section 10 - 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 11 - Person Who Will Represent the Proposed Representative 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 12 - 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 33(1) / 51(1) / 66(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.