Ontario

Consent and Capacity Board

Form C - Application to the Board to Appoint a Representative under Subsection 33(2), 51(2) or 66(2) of the *Health Care Consent Act.*

Section 1 - Applicant (Proposed Representative)

Last Name		First Name	
Unit Number	Street Number	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 be appointed as a representative for the person named below. This application is made with respect to:

☐ a health practitioner's finding that this person is incapable of consenting to their treatment

Specify:

☐ an evaluator's finding that this person is incapable of consenting to their admission to a Long Term Care Home

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

Section 3 - Patient/Resident

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

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City/Town	Province	Postal Code

Telephone No. (including area code)	Fax Number	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 admission to the facility. This will usually be a person from the Local Health Integration Network.

☐Same as Section 4

Last Name	First Name

Unit Number	Street Number	Street Name	PO Box

City/Town	Province	Postal Code

Telephone No. (including area code)	Fax Number	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 Number	Street Number	Street Name	PO Box

City/Town	Province	Postal Code

Telephone No. (including area code)	Fax Number	Email Address

Section 8 - Information About the Facility

Is the Patient/Resident currently an in-patient or resident at a health or residential facility

☐Yes, provide information about the facility ☐No

Name of Facility	Ward

Unit Number	Street Number	Street Name	PO Box

City/Town	Province	Postal Code

Contact Name (First Name, Last Name)	Telephone No. (including area code)	Fax Number

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 Number	Street Number	Street Name	PO Box

City/Town			Province	Postal Code
Telephone No. (including area code)	Fax Number	Email Address		
Last Name	First Name	Relationship		
Unit Number	Street Number	Street Name		PO Box
City/Town			Province	Postal Code
Telephone No. (including area code)	Fax Number	Email Address		
Last Name	First Name	Relationship		
Unit Number	Street Number	Street Name		PO Box
City/Town			Province	Postal Code
Telephone No. (including area code)	Fax Number	Email Address		
Last Name	First Name	Relationship		
Unit Number	Street Number	Street Name		PO Box
City/Town			Province	Postal Code
Telephone No. (including area code)	Fax Number	Email Address		
Last Name	First Name	Relationship		
Unit Number	Street Number	Street Name		PO Box
City/Town			Province	Postal Code
Telephone No. (including area code)	Fax Number	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 (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 11 - 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(2) / 51(2) / 66(2) 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.