Ontario

Consent and Capacity Board

Form F - Application to the Board with Respect to Place of Treatment under Subsection 34(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		

I apply to the Board for a review of a decision made on my behalf, to consent to my admission to a hospital, psychiatric facility or other health facility for the purpose of treatment. A health practitioner has found that I am incapable with respect to the following treatment:

Specify Treatment

and a Substitute Decision Maker has consented to my admission to the following hospital, psychiatric facility or other health facility for the purpose of receiving that treatment, course of treatment or plan of treatment.

Section 2 - Information About the Hospital, Psychiatric Facility or Other Health Facility

Are you currently an in-patient or resident at a health or residential facility ◯No ◯Yes, provide information about the facility

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 3 - The Person Who Consented to the Admission

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 4 - Person Who Made the Finding of Incapacity

***Note: An application may only be made if a health practitioner has made a relevant finding of incapacity to consent to a treatment, course of treatment or plan of treatment.**

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

☐ 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 6 -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 7 - Person Who Will Represent the Person Who Consented to the Admission 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 8 - Other Information That Will Assist Us in Arranging the Hearing (i.e. Interpreter, Special Assistance)

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 34(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 or 1 877 301-0889 (TTY).