Ontario

Consent and Capacity Board

Form H - Application to the Board to Amend the Conditions of, or Terminate the Appointment of a Representative under Subsection 33(7) and (8), 51(6) or 66(6) of the *Health Care Consent Act.*

Section 1- Applicant

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 - Purpose of Application

I apply to the Board to Amend the Conditions of, or Terminate the Appointment of a **Consent and Capacity Board Appointed Representative** as follows:

- ☐ remove a condition imposed on the appointment of the representative
- ☐ vary a condition imposed on the appointment of the representative
- ☐ suspend a condition imposed on the appointment of the representative
- ☐ impose an additional condition on the appointment of the representative
- ☐ terminate the appointment of the representative

Section 3 - 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 4 - Finding of Incapacity

This Patient/Resident has been found incapable with respect to:

- ☐ Consenting to their treatment

Specify:

- ☐ Consenting to their admission to a Long Term Care Home
- ☐ Consenting to receiving personal assistance services in a Long Term Care or Retirement Home

Section 5 - Consent and Capacity Board Appointed 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	

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Section 6 - 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 7 - Health Practitioner Who Proposed the Treatment

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

☐ Same as Section 6

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 - Person Responsible for Authorizing Admission to Long-Term Care

If this application refers to **admission to a care facility**, 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 6

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 - 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 6

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 10 - Information About the Facility

Is the Patient/Resident 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 11 - 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 12 - 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 13 - Person Who Will Represent the Board Appointed 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 14 - 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(7)(8) / 51(6) / 66(6) 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.