Ontario

Consent and Capacity Board

Form P2 - Application to the Board to Determine Compliance under Subsection 24(2) of the *Personal Health Information Protection Act*

Section 1 - Applicant

Last Name	First Name

Organization or Agency

Unit No.	Street No.	Street Name	PO Box

City/Town	Province	Postal Code

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

☐ I am the health information custodian authorized to make the application.

Section 2 - Application Type

I apply to the Board for a determination as to whether or not the Substitute Decision Maker in this case has complied with the principles for substitute decision-making as they are set out in the Act. This application is made with respect to:

☐ collection of personal health information

☐ use of personal health information

☐ disclosure of personal health information

Section 3 - Individual to whom the determination of incapacity applies

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 Information Custodian Who Made the Determination of Incapacity

Note: An application may only be made if a health information custodian has made a relevant determination of incapacity

☐ Same as Section 1

Last Name	First Name

Organization or Agency

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 - Substitute Decision Maker for the Individual to whom the determination of incapacity applies

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 - Facility

Is the Individual 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 7 - 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 8 - Person Who Will Represent the Substitute Decision Maker 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 - Person Who Will Represent the Individual to Whom the Determination of Incapacity Applies 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 10 - 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 24(2) of the *Personal Health Information Protection 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).