Ontario

Consent and Capacity Board

Form P5 - Application to the Board to Amend the Conditions of, or Terminate the Appointment of a Representative under Subsection 27(7) or (8) of the *Personal Health Information Protection 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 - 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

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 - Consent and Capacity Board Appointed Substitute Decision Maker

Note: An application may only be made if the CCB has previously appointed a substitute decision maker under the *Personal Health Information Protection Act.*

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/Location in Facility	
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 - List Spouse, Partner, Parents, Siblings and Children of Individual to Whom the Determination of Incapacity Applies

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 Individual to whom the determination of incapacity applies is under 18 years old, you must also list any agency or person legally authorized to provide consent with respect to personal health information on his or her 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 11 - 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 27(7), (8) 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).