Ontario Ministry of Health

Information in Support of a Warrant to Apprehend and Return a Child Who has Been Admitted to a Secure Treatment Program

Ontario Court (Provincial Division)	Court file no.

at

Unit No.	Street No.	Street Name	PO Box
City/Town		Province	Postal Code

This is the Information of

Name of Informant

Last Name	First Name	Middle Initial

of

Unit No.	Street No.	Street Name	PO Box
City/Town		Province	Postal Code

I am the administrator of the secure treatment program at

Name of program

Address

Unit No.	Street No.	Street Name	PO Box
City/Town		Province	Postal Code

I believe that

Name of Child

Last Name	First Name	Middle Initial

who is a child who was committed to the secure treatment program named above, has left the facility where the secure treatment program is located without my consent.

(Do not complete if not applicable)

I believe that the child may be found at

Address

Unit No.	Street No.	Street Name	PO Box
City/Town		Province	Postal Code

Unit No.	Street No.	Street Name	PO Box
City/Town		Province	Postal Code

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Sworn (or affirmed) before me this | Day | day of | Month | Year

at the | of

in the | of

A justice of the peace in and for the Province of Ontario

Signature of Informant

Information on this form is collected under the legal authority of the *Child, Youth and Family Services Act*, *2017* for the purpose of administering Ministry of Health programs and/or services. For more information contact: Director, Mental Health and Addiction Programs Branch, 56 Wellesley St W., 9th Floor, Toronto ON, M5S 2S3 or call 416-327-7272.