Ontario

Ministry of Health

Tuition Support Program for Nurses – Consent to Collection and Disclosure of Personal Information

Instructions

Please return signed copies to:
Primary Health Care Branch
Northern Health Programs
NHP@ontario.ca

Funds provided through the Tuition Support Program for Nurses are subject to federal and provincial income tax.

Personal information contained on this document is collected by virtue of it being necessary for the proper administration of a lawfully authorized activity pursuant to Section 8 of the *Ministry of Health and Long-Term Care Act*, RSO 1990, Chapter M. 26. and, more specifically, for the purpose of establishing eligibility for the Tuition Support Program for Nurses. For information about this collection, please contact Northern Health Programs toll free at 1-866-727–9959 or via email at NHP@ontario.ca.

Consent to Collection and Disclosure of Personal Information

A. I, _____, wish to inform you that I accept the Ministry of Health's offer of a reimbursement of tuition fees in exchange for return of service in an eligible underserviced community and facility, in accordance with the Ministry's Tuition Support Program for Nurses ("Program"), and accordingly I agree to fulfill all of the terms and conditions of the Program.

B. I authorize the Ministry to collect from, and/or disclose to, the following bodies or persons all of my personal information that is pertinent to my participation in the Program and to the fulfillment of my commitment to return service in an eligible underserviced community and eligible facility:

(i) the following Canadian universities, colleges and facilities from which I have successfully graduated from an accredited nursing program:

1. _____
2. _____
3. _____

(ii) the following hospital, facility, clinic, office, or agency ("facility") in a Ministry approved eligible underserviced community (as set out in my Confirmation of Employment) where I propose to return service under the Program:

Name of facility

_____

Name of community

_____

Where I wish to return service in more than one facility and/or underserviced community, the following additional facility and/or community:

Name of facility

_____

Name of community

_____

C. I also agree to participate fully in one or more evaluation or other similar studies of the Program at the direction of the Ministry.

Signature of Return-of-Service Nurse

Signature	Name (First Name and Last Name)	Date (yyyy/mm/dd)

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