

## Form 2 – Applicant Report

Pursuant to the *Mandatory Blood Testing Act, 2006*  
and O. Reg. 449/07

### TO BE COMPLETED BY THE APPLICANT

You may submit an application if:

- you came into contact with a bodily substance of another person and want to have their blood analysed for HIV/AIDS, Hepatitis B or Hepatitis C; and
- You came into contact with the bodily substance as a result of being a victim of crime; while providing emergency health care services or emergency first aid; or you fall under one of the prescribed classes or circumstances (see section C).

You must deliver one copy of this form, together with a completed Form 1 – Physician Report to the Medical Officer of Health in the appropriate health unit<sup>1</sup>. The application must be received by the Medical Officer of Health **no more than seven days** after you came into contact with the bodily substance (if the deadline falls on a Saturday, Sunday or holiday, it shall be extended by one day).

If you submit an application under the *Mandatory Blood Testing Act, 2006*, you must consent to:

- (a) The disclosure of the personal information and personal health information related to the application to the Consent and Capacity Board, if there is a hearing.
- (b) Examination, counselling (including counselling respecting prophylaxis or treatment), and baseline testing for HIV/AIDS, Hepatitis B and Hepatitis C.

- (c) The release by the police of any information from the police report to the Consent and Capacity Board (where an application is made as a victim of crime), in the event that the application is referred to the Board.

If the form is not filled out completely or you fail to meet the prescribed requirements, the application shall not proceed. You will be notified within two days of this fact by the Medical Officer of Health by registered mail.

If your application meets the requirements, the Medical Officer of Health will disclose the details of the occurrence, as described in this report and the physician report, to the respondent (the Medical Officer of Health shall not reveal your personal information).

If the respondent does not comply with a request for voluntary compliance and provide proof of such compliance, your application will be referred to the Consent and Capacity Board for a hearing. Hearings before the Consent and Capacity Board are public.

**You must ensure that a valid copy of your baseline testing is submitted to the Consent and Capacity Board as soon as the results are available.** The Consent and Capacity Board may be reached via fax at 416 924-8873 or 1 866 777-7273. Keep one completed copy of this form and one completed copy of the physician report for your own records.

### A. Applicant Information

Collection, use and disclosure of the personal information on this form is for consideration of an application under the *Mandatory Blood Testing Act, 2006* requiring a respondent to give a blood sample to determine the HIV/AIDS, Hepatitis B and/or Hepatitis C status of the respondent. The authority for collection and use of this information is the *Mandatory Blood Testing Act, 2006*. For information about collection practices contact the Policy Development and Coordination Branch, Ministry of Community Safety and Correctional Services at 416 212-4221.

#### Applicant's Full Name

Last Name	First Name	Middle Name
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#### Applicant's Address

- Home Address       Place of Employment

Unit Number	Street Number	Street Name				
City/Town		Province <b>Ontario</b>	Postal Code	Home Telephone (    )	Business Telephone (    )	
OHIP Number (10 digits)			Version	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Age	Date of Birth (yyyy/mm/dd)

#### Family Physician - if Different from Reporting Physician

Last Name	First Name	Middle Initial
Unit Number	Street Number	Street Name
City/Town		Province <b>Ontario</b>
Postal Code	Office Telephone (    )	Office Fax Number (    )

<sup>1</sup> "appropriate health unit" means the health unit in the area where the respondent resides. For a list of health units and the areas they comprise, call the INFOline at 1-866-532-3161.

**B. Identification of Respondent - The following information about the respondent is mandatory**

**Note: The respondent is the person whose bodily substances you may have come into contact with. If this form does not include the name and address of the respondent, the application shall not proceed.**

**Respondent's Full Name**

Last Name	First Name	Middle Name
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**Full Address**

Unit Number	Street Number	Street Name
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City/Town	Province <b>Ontario</b>	Postal Code
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The following information about the respondent must be provided **if known**

Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Age	Date of Birth (yyyy/mm/dd)	Home Telephone ( )	Business Telephone ( )
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**C. Details of Occurrence - Date, time and location where you may have come into contact with a bodily substance of the respondent**

Date (yyyy/mm/dd)	Time <input type="checkbox"/> am <input type="checkbox"/> pm	Unit Number	Street Number	Street Name
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City/Town	Province <b>Ontario</b>	Postal Code
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Describe the circumstances in which you may have come into contact with a bodily substance of the respondent

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Describe any injuries you sustained

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Did you take any precautions before (i.e. wearing gloves, goggles, mask, etc.) and after (i.e. immediately washing the exposed area) your contact with the bodily substance of the respondent?  No  Yes, *explain*

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## E. Consent to Examination, Counselling and Baseline Testing

I hereby consent to examination by the physician preparing the physician report which accompanies this form, to counselling (including counselling respecting prophylaxis and treatment) and to baseline testing for the listed communicable diseases ordered by the reporting physician.

Yes  No

**Note: You must consent to examination, counselling and baseline testing. Otherwise, the application is invalid and may not proceed under the Mandatory Blood Testing Act, 2006.**

## F. Treatment

Was Hepatitis B vaccine recommended as a treatment for you?  Yes  No

Was HIV prophylaxis recommended as a treatment for you?  Yes  No

I took the recommended Hepatitis B vaccine  Yes  No

I took the recommended HIV prophylaxis  Yes  No

Was HBIG recommended as a treatment for you?  Yes  No

I am still taking this treatment  Yes  No

I took the recommended HBIG  Yes  No

Date I stopped treatment  
- if applicable

yyyy/mm/dd

## G. Consent to Disclosure of Personal Information

I hereby consent to the release of my personal information and personal health information related to this application to the Consent and Capacity Board, in the event that the application is referred to the Board for a hearing called for the purposes of considering an order requiring a respondent to give a blood sample to determine his/her HIV/AIDS, Hepatitis B and/or Hepatitis C status.

Yes  No

**Note: You must consent to the release of your personal information and personal health information to the Consent and Capacity Board. Otherwise, the application is invalid and may not be considered under the Mandatory Blood Testing Act, 2006.**

## H. Information Accurate

I hereby confirm that the information provided in this form is accurate to the best of my knowledge.

Name of Applicant - please print

Last Name

First Name

Middle Initial

Signature

Date (yyyy/mm/dd)