Applicant's Last Name, First Name *(PLEASE PRINT)*	Health Number *(10 digits)*	Version

Section 3 – Applicant's Consent and Signature

NOTE: This section of the form may be signed only by the applicant or his or her agent

I consent to the Ministry of Health and Long-Term Care (the Ministry) collecting the information I provide on this form for the purpose of assessing and verifying my eligibility to receive benefits under the Ministry's Assistive Devices Program (the "Program"). In addition, I consent to the Ministry and the Workplace Safety and Insurance Board (WSIB) collecting, using and disclosing personal information about me, including the information on this form and information related to my entitlement to health care benefits under the *Workplace Safety and Insurance Act* ("WSIA"), for the purpose of assessing and verifying my eligibility to receive benefits under the Program and WSIA.

The Ministry and WSIB will limit the information that they exchange about me to only that information that is necessary for the purpose above.

The Ministry will only use and disclose my personal health information in accordance with the *Personal Health Information Protection Act, 2004*, and the Ministry's "Statement of Information Practices" which is accessible at: www.health.gov.on.ca. In addition, the WSIB will collect, use and disclose personal information about me from the Ministry for the purpose of administering and enforcing the WSIA.

I understand that if I choose to withhold or withdraw my consent to the collection, use and disclosure of this information by the Ministry or WSIB, I may be denied coverage under the Program.

For more information on the Ministry's Information Practices, or the collection, use or disclosure of the personal information on this form, call 1-800-268-6021/416-327-8804 or TTY: 416-327-4282 or write to the Program Manager, 5700 Yonge Street, 7th Floor, Toronto ON M2M 4K5.

I have read the Applicant Information Sheet, understand the rules of eligibility for ADP and am eligible for the equipment specified.

I certify that the information I have provided on this form is true, correct and complete to the best of my knowledge. I understand that this information is subject to audit.

Signature		Date *(yyyy/mm/dd)*
X	☐ Applicant ☐ Agent	/ /

If the above signature is not that of the applicant, specify relationship to applicant and fill out contact information

☐ Spouse ☐ Parent ☐ Legal Guardian ☐ Public Trustee ☐ Power of Attorney

PLEASE PRINT

Last Name	First Name	Middle Initial

Address

Building Number	Street Name	Suite/Apt Number

Lot/Concession/Rural Route	City/Town	Province	Postal Code

Home Telephone *(include area code)*	Business Telephone *(include area code)*	Ext
- -	- -	

Section 4 – Signatures

Prescriber's Signature

I hereby certify that I have personally assessed the applicant in person and determined that the applicant has a chronic physical disability requiring the regular use of the prescribed Ocular Prosthesis(es).

PLEASE PRINT

Physician/Optometrist's Last Name	Physician/Optometrist's First Name

Business Telephone *(include area code)*	Ext	Ontario Health Insurance Billing No *(6 digits)*
- -		

Physician/Optometrist's Signature	Date Signed *(yyyy/mm/dd)*
X	/ /

Brett Ocular Prosthetics
125 - 339 Wellington Rd. S.
London, Ont. N6C 4P8