Ontario Ministry of Health and Long -Term Care

TB - UP Application and Consent

APPLICATION and AUTHORIZATION for the
Tuberculosis Diagnostic and Treatment Services for Uninsured Persons (TB-UP) Program

Part A - To be completed by Board of Health

Name of Health Unit	Telephone number ( )

Address

Unit	Number, street name

City/Town	Prov. ON	Postal code

Part B - To be completed by TB - UP Registrant

Name of Registrant in full - ***please print***

Last name	First name	Middle name
Date of birth *(month/day/year)*	Gender ☐ Male ☐ Female	Telephone number ( )

Name of Guardian/Parent (if under 16 years) - ***please print***

Last name	First name	Middle name	Telephone number ( )

Address of Registrant

Apartment/Unit	Number, street name

City/Town	Prov. ON	Postal code

- At present, I am not an insured person under the Ontario Health Insurance Plan (OHIP).

  I am not entitled to health services under the Interim Federal Health Plan.

  I do not have any other health insurance that will cover these services.

  Should I become an insured person under the Ontario Health Insurance Plan or any other health care coverage that will pay for these services, I agree to immediately advise the board of health or my health care providers.

- I hereby ask to be registered in the Tuberculosis Diagnostic and Treatment Services for Uninsured Persons (TB-UP) program*.

  I authorize the board of health, health care providers providing services to me under TB-UP and the Ministry of Health and Long-Term Care to collect, use, share and disclose my personal health information among themselves only for the purposes of the TB-UP program, including purposes related to my health care, payment of provincially funded compensation to my TB-UP health care providers and provincial health program evaluation and health planning.

- I also agree that if I become an insured person under the Ontario Health Insurance Plan the Ministry of Health and Long-Term Care may release my health number to health care providers providing tuberculosis diagnostic and treatment services.

- If I wish to withdraw this Application and Authorization I will notify the Board of Health named above.

Signature *(Registrant or Guardian/Parent if under 16 yrs.)*	Date - *month/day/year*

Part C - To be completed by Witness

Name of Witness in full - ***please print***

Last name	First name	Middle name
Signature of Witness		Date - *month/day/year*

Address of Witness

Apartment/Unit	Number, street name

City/Town	Prov. ON	Postal code

*The TB-UP program is authorized pursuant to the provisions of sections 2(purpose), 4 (duty of boards of health), 5.2 (control of disease), 5.4.1(collection and analysis of data), 7 (guidelines for provision of mandatory programs) and 25, 26, 29 and 31 (reporting of disease) under the *Health Protection and Promotion Act,* and section 6 (duties and functions of the Minister), under the *Ministry of Health and Long-Term Care Act.*

Collection of the personal information on this form is for determination of eligibility and registration in the TB-UP program, provision of TB-UP health services, TB-UP program administration and health program evaluation and planning. The authority for collection and use of this information is the *Ministry of Health and Long-Term Care Act*, section 6, and the *Health Protection and Promotion Act,* sections 2, 4, 5.2, 5.4.1 and 25, 26, 29 and 31. For information about collection practices contact the TBUP Program: Nursing Consultant at telephone 416-327-7419.