College of Chiropodists of Ontario

Patient Explanation and Consent Form

For Reporting Abuse by a Health Practitioner

PRACTITIONER REQUIREMENTS

By law, every registered health care practitioner must report sexual abuse by another practitioner. He or she has no choice.

PATIENT OPTIONS

You can put your name in the report, or you can remain anonymous. If you decide not to sign this consent form, your name will not be included in the report.

To help you decide whether to allow your name to be included in the report, please consider the following:

- The report will be sent to the College of _____(that is the group that regulates the health care practitioner who abused you.)
- By disclosing your name it may be possible to take some action to prevent the practitioner from abusing other patients. The practitioner may be disciplined.
- If you do not disclose your name it will be very difficult for the College of _____ to act on the report because there will be no evidence.
- If you consent to your name being disclosed, you will likely be approached by a representative of the College of _____ who will explain what can be done about the practitioner who abused you, and will also ask you if you would be willing to help the College of _____ _____ deal with the person who abused you. You can ask this representative any questions you may have.

If you have any questions before deciding whether to sign this consent form, please call The Registrar of College of Chiropodists of Ontario.

If you wish to give your consent to your name being included in the report, please sign the consent on the following page. The choice is yours.

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Suite 2102
Toronto, ON M5G 1Z8

Tel: 416 542 1333
Toll Free only in Ontario except 905 & 416)
1 877 232 7653
Fax 416 542 1666

www.cocoo.on.ca

INFORMED CONSENT FORM

I was a patient of _____ (the practitioner).
[Name of practitioner being reported]

_____ has told me that he or she must report the practitioner
[Name of reporting person]

for his or her sexual abuse of me. I consent to my name being included in the report.

_____ _____
(Signature of witness) *(Signature of patient)*

_____ _____
(Print name) *(Print name)*

_____
Date