PROTECTED B (when completed)

Medical Declaration

I, _____ am a licensed Physician/Nurse Practitioner in the province/territory of _____ .

I hereby certify that _____ (*patient's full name*), _____ (*date of birth*):

Has a medical contraindication and/or medical reason precluding full vaccination against COVID-19 as described by the National Advisory Committee on Immunization.

This medical reason is (please indicate only one):

- ☐ Permanent
- ☐ Time limited and will be in effect until _____

Signature: _____

Date: _____

Name: _____

Telephone number: _____

License Number: _____

Province/Territory: _____

Privacy Statement

The purpose for collection and use of this information is to determine whether you meet the entry requirements for CSC institutions during the COVID-19 pandemic. Personal information is collected pursuant to the *Corrections and Conditional Release Act* and in accordance with the *Privacy Act*. Information supplied on this form will be used to consider your request for exemption to the COVID-19 proof of vaccination requirements in accordance with CSC's Integrated Risk Management Framework.

A copy of the decision letter and your supporting documentation will be kept on the Visits and Correspondence file.

Under the *Privacy Act*, you have the right to access your personal information and request corrections to your information. You are entitled to request a correction in respect of any error in the personal information disclosed to you. A “Record Correction Request Form” may be completed should you wish to exercise this right pursuant to section 12(2) of the Privacy Act. Please note, documentary proof may be requested before the corrections are effected.

You are entitled to file a complaint with the Office of the Privacy Commissioner of Canada. Should you wish to exercise this right, your complaint should be forwarded to the Office of the Privacy Commissioner, 30 Victoria Street, 1st Floor, Gatineau, Quebec K1A 1H3