Participant Contact Information

Name: ______________________________, ____________________________, ___________________________
Last Name First Name Middle Name

Date of Birth (dd/mm/yyyy): ___ ___ / ___ ___ / ___ ___ ___ ___ Sex: Male ☐ Female ☐

Home Address: __________ ____ ___________
Street # Street Name Apartment #

City: ______________________ Province: __________________ Postal Code: _____________

Home Phone: ________ - ________ - __________ Cell Phone: ________-________-__________

E-mail Address: ____________________________ Ontario Health Card Number: ______________________

Alternate Contact 1:

Name: ______________________________, ____________________________, ___________________________
Last Name First Name Middle Name

Relationship to Patient: ______________________ E-mail Address: _______________________________

Home Address: __________ ____ ___________
Street # Street Name Apartment #

City: ______________________ Province: __________________ Postal Code: _____________

Home Phone: ________ - ________ - __________ Cell Phone: ________-________-__________

Alternate Contact 2:

Name: ______________________________, ____________________________, ___________________________
Last Name First Name Middle Name

Relationship to Patient: ______________________ E-mail Address: _______________________________

Home Address: __________ ____ ___________
Street # Street Name Apartment #

City: ______________________ Province: __________________ Postal Code: _____________

Home Phone: ________ - ________ - __________ Cell Phone: ________-________-__________

As of September 5, 2018