

Form 3 (CCA)
CARE CONSENT ACT
Section 61(4)

CANCELLATION OF CERTIFICATE OF NEED FOR FINANCIAL PROTECTION

INSTRUCTIONS

This form must be filled out by a health care provider. Copies of this form	must be provided to the:
Public Guardian and Trustee; and	
are recipient.	
Re:	
Print full n	ame
of	
currently residing at	rent place of residence if different from above
l,	
Print name of health c	
OfPrint name of medical clinic or health	state that:
Time name of medical clime of nearth	real facility
1. I examined the above-named person on	Date (day/month/year)
 I believe on reasonable grounds, that the above-named period incapable of making reasonable decisions regarding their named person no longer needs financial protection. 	erson is not , because of a health condition,
DATED at, this, day of, month year	SIGNATURE OF HEALTH CARE PROVIDER
this, day of,,	
) -	PRINTED NAME OF HEALTH CARE PROVIDER
SIGNATURE OF WITNESS	

Information on this form is being collected pursuant to the *Care Consent Act* to meet the requirements for cancelling Form 2 (CCA), Certificate of Need for Financial Protection. For more information, contact the Health and Social Services ATIPP Coordinator (H-1), Box 2703, Whitehorse Yukon, Y1A 2C6, (867) 667-3010.