

Sentinel Practitioner Surveillance Network Consent Form



Written consent for sentinels related to the Sentinel Practitioner Surveillance Network (SPSN)

I, _____ (Please print name)

agree to being contacted by the Ontario Vaccine Effectiveness program coordinator and to participating in the SPSN for the 2026-2027 season. I understand that, in providing my contact information below, I may, at any time, decline further study-related contact or withdraw the participation of my practice from this network without penalty. It is agreed that my practice and patient contact information will remain confidential without any personal identifying information being shared and will only be used for the purpose of communicating laboratory results, updating on SPSN progress or completing other network-related purposes.

Please complete form

Full Name:

Address:

Postal Code:

City:

Province:

Office phone number:

Fax number:

Email:

Signature:

I need more information before consenting: Yes No

Please fax or email the completed form to SPSN Coordinator:

Fax 647-792-3440 or email to SPSN.ON@oahpp.ca