Sentinel Practitioner Surveillance Network

Consent Form

Public Health Ontario | Santé publique Ontario

SPSN

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 2025-2026 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 416-596-1799 or email to SPSN.ON@oahpp.ca

Ontario