Yukon
Health and Social Services

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

CANCELLATION OF CERTIFICATE OF NEED FOR FINANCIAL PROTECTION

I N S T R U C T I O N S

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
- ☐ care recipient.

Re: _____
Print full name

of _____
Home address

currently residing at _____,
Name of facility or other current place of residence if different from above

I, _____
Print name of health care provider

of _____state that:
Print name of medical clinic or health care facility

1. I examined the above-named person on _____
Date (day/month/year)

2. I believe on reasonable grounds, that the above-named person is **not**, because of a health condition, incapable of making reasonable decisions regarding their financial affairs. I hereby certify that the above-named person no longer needs financial protection.

DATED at _____,

this_____ day of_____ , _____.
month year

_____
SIGNATURE OF HEALTH CARE PROVIDER

_____
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.