**FAX**

|  |  |  |  |
| --- | --- | --- | --- |
| To: | Assessment Centre | Re: | Symptomatic Household Member/ Essential Care Provider |
| Organization: |  | Pages (including cover sheet): | |
| Recipient Fax: | (807) 623-6631 | Sender Name: | |
| Recipient Phone: (807) 935-8101 | | Sender Phone: | |
| Date: |  | Confirmation of Receipt Requested: 🞏 Yes 🞏 No | |  |

Symptomatic household member

Staff name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Household member name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Household member phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Department: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Manager signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Essential care provider

ECP name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ECP phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Department: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Manager signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_