Ontario Health
Cancer Care Ontario

Registration Form for the ColonCancerCheck (CCC) Program Provider List to Support Unattached Participants

Upon completion, please fax or email this form to: 416-971-6888 or cancerinfo@ontariohealth.ca.

As part of the CCC program, unattached participants (those without a primary care provider) can be screened for colorectal cancer, for example, by contacting Health811. If unattached participants have an abnormal fecal immunochemical test (FIT) result or contacts Ontario Health (Cancer Care Ontario) because they are at increased risk for colorectal cancer, the CCC program will connect them to a provider for a referral to colonoscopy. By providing the information below, you are registering to be added to Ontario Health (Cancer Care Ontario)'s list of providers who are available to support unattached participants by referring them to colonoscopy. You will be added to the provider list as of the date of form completion and can remove your name from this list at any time by calling 1-866-662-9233. As a registered provider, you are not required to support comprehensive care for these unattached participants. However, if you are in a patient enrolment model (PEM), you can claim the Q043A New Patient Fee upon enrolling people referred from Ontario Health (Cancer Care Ontario) to your patient roster. For more details, please see the Ontario Health Insurance Plan Schedule of Benefits.

Your professional information is being collected to create the list of providers available to support unattached participants. Once a participant has been connected to you, your professional information will be used by Ontario Health (Cancer Care Ontario) in accordance with provisions of the *Personal Health Information Protection Act, 2004*, Ontario's health information privacy law. Questions about this collection should be directed to primarycareinquiries@ontariohealth.ca.

Asterisk (*) indicates mandatory fields.

*Provider's first and last name:

*CPSO/CNO Registration number:

*Languages served:

Please include all the requested information for your primary practice as well as additional locations from which you practice and are willing to support unattached participants in the CCC program. Please check the box indicating your preferred method of communication and ensure that the information you provide relates to your professional capacity.

*Practice location #1 (preferred)	Practice location #2 (optional)
*Address:	Address:
Province: ON	Province: ON
*Postal code:	Postal code:
*Phone number:	Phone number:
*Fax:	Fax:
Email address:	Email address:

***Provider signature:** ***Date:**