ACE NEWSLETTER

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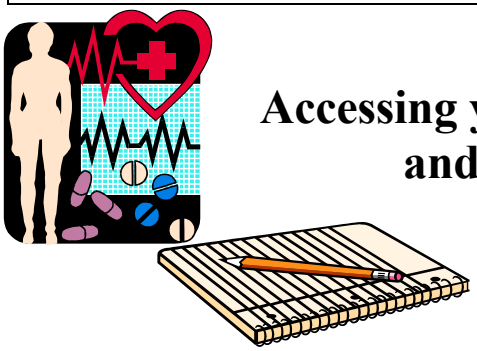

Accessing your Medical Records in the Hospital and in Long-Term Care Facilities

Amy Shoemaker, LL.B., LL.M.
Institutional Advocate

People often find it a confusing and complicated process accessing their medical records in a hospital or long-term care facility. The following discussion outlines your rights in relation to medical records in these facilities, and provides basic practical information as to how to obtain copies of your records.

Supreme Court of Canada Decision in *McInerney v. MacDonald*

In 1992, the Supreme Court of Canada delivered a judgment in the case of *McInerney* v. *MacDonald* concerning access to medical records. This decision established that patients and residents have a right to see and make copies of their medical records. This is based on the concept that when a person provides information to a health care practitioner, this information belongs to the patient. In the absence of legislation, a patient is entitled, upon request, to examine and copy all information in his medical records which the physician considered in administering advice or treatment, including records prepared by other doctors that the physician may have consulted. The central issue in *McInerney* was whether a doctor could withhold medical records compiled by other physicians. This is very relevant in cases involving long-term care facilities and hospitals because the records will often contain reports from a number of consulting physicians. The court made it clear that a resident would have the right to the reports compiled by other physicians.

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According to the Supreme Court of Canada, the patient is not entitled to the records themselves. The physical medical records of the patient belong to the doctor. However, certain duties arise from the special relationship of trust and confidence between doctor and patient. When a patient confides information to the physician, there is an expectation that the patient's interest in and control of the information will continue. Therefore, a patient has a right to access his own medical records. However, the right is not absolute. A doctor can deny access where the doctor believes that access would result in a substantial risk to the physical, mental or emotional health of the patient or harm to another person. This discretion may be used for very limited purposes. Records cannot be withheld arbitrarily on the basis that a patient or resident might not understand them or because of the fear of unfounded lawsuits. The onus is on the physician to justify a denial of access.

Medical Records in a Hospital

According to the *Public Hospitals Act*, the medical record compiled in a hospital for a patient or an out-patient is the property of the hospital and shall be kept in the custody of the administrator. However, patients have the right to access their medical records in a hospital. To obtain access, contact the clinical or medical records department. Each hospital has a policy regarding access to medical records and they may require a signed consent from the patient or a written request.

In cases where a patient has been found incapable to consent to treatment, the patient's substitute decision-maker will have the same right of access to the records as the patient themselves. The *Health Care Consent Act* provides a mechanism for substitute decision-making. In the case where a person has been found incapable to consent to treatment, admission to a care facility or personal assistance services, this legislation sets out the people who may make a decision on behalf of the incapable person. A substitute decision-maker includes a guardian of the person, an attorney for personal care, as well as the hierarchy of substitute decision-makers listed in the *Health Care Consent Act*. The clinical records department may request a written consent from the substitute decision-maker. Where an attorney for personal care is requesting access, the hospital may request a copy of the power of attorney for personal care.

There is often a misunderstanding on the part of hospital staff regarding the type of consent that must be signed. Hospitals will often require the patient to sign a Form 14 consent. However, this is not the appropriate form to sign unless the records are psychiatric records, as described in the *Mental Health Act*. If the records are not psychiatric records, the hospital may require a signed letter or a simple consent in order to permit access to the records.

The *Health Care Consent Act* permits a person to challenge a finding that they are incapable of making decisions in relation to treatment, admission to a care facility, or personal assistance services. A challenge is initiated by filing an application for a hearing before the Consent and Capacity Board. After applying to the Board to challenge a finding of incapacity, the applicant and the applicant's counsel or agent are entitled to examine and copy any medical or other health record relating to the applicant. Therefore, patients and their lawyers or agents have a right to access their medical records when they have applied for a hearing before the Consent and Capacity Board.

Hospitals may charge a fee for copying medical records. It is important to inquire about any copying charges prior to requesting the records.

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HOMECARE SERVICE CUTS: CAN THEY BE CHALLENGED?

By George T. Monticone

In recent months Community Care Access Centres (CCACs) throughout Ontario have begun to advise clients of cutbacks to in-home care services because of funding problems. For example, some CCACs have announced that homemaking services will no longer be offered. If a CCAC terminates or reduces particular services to clients, or announces it cannot offer them to new applicants for services, where the reason is that the CCAC has a policy to this effect, the client or potential client can challenge the CCAC.

The *Long-Term Care Act, 1994* governs the provincial in-home care system. Section 11 of that Act says that a CCAC "**shall provide or ensure the provision of** the following services in the geographic area for which the agency is designated" (emphasis added). Four types of services are then listed: community support services, homemaking services, personal support services, and professional services. In section 2 of the Act, each of these categories is defined more specifically. For example, homemaking is defined as including housecleaning, laundry, ironing, mending, shopping, banking, paying bills, preparing meals, etc.

The effect of section 11 of the Act is to legally require CCACs to provide each of the four classes of services listed, and arguably, each of the specific services in each class listed in section 2. Therefore, a CCAC policy which says that there shall be no more services of a specific kind is open to challenge as it violates the Act.

In the Spring 2001 edition of the *ACE Newsletter* we outlined the process to follow if you are unhappy about a CCAC decision to reduce or terminate services ("Your In-Home Services Are Being Cut or Terminated: What Should You Do?"). Each CCAC is required by law to have an internal appeal/complaints process. You may use this process to appeal a decision to cut or terminate services. You may argue that as your needs remain the same or have increased, a reduction or termination of services is not justified. If the CCAC decision you are challenging is based on a policy to the effect that particular kinds of services are not being offered, this gives you an additional grounds to challenge the decision. If after exhausting the CCAC appeals, the decision of the CCAC remains the same, you may want to appeal that decision to the Health Services Appeal and Review Board. While it is possible to do so without legal advice, you may want to seek legal advice at this stage.

The **Advocacy Centre for the Elderly (ACE)** is a legal clinic for low income seniors 60 years of age and over, funded by Legal Aid Ontario. ACE is incorporated as a non-profit corporation under the name "Holly Street Advocacy Centre for the Elderly Inc.".

Charitable Registation No. 0800649-59

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ACE
Annual General Meeting
Thursday, October 18, 2001, 7 p.m.
Toronto YMCA
20 Grosvenor Street
Guest Speaker:
Shirley Douglas
Privatization of the Canada Health System

Consumer Protection Act Improved by Ontario Government

The *Consumer Protection Act*, which deals with sales made in a place other than the seller's permanent place of business, has recently been amended to improve the protection offered to consumers. The Act now applies to a broader range of sales, and the seller is now required to disclose more information than before. In addition, the cooling-off period during which a consumer may cancel the transaction has been extended from 48 hours to 10 days.

Consumer Protections Prior to the Amendments

Previously, the Act applied to contracts worth $50.00 or more, signed in the consumer's home, which have not yet been completed. The consumer could cancel such contracts within 48 hours by letter to the seller. The letter had to be either registered at the post office within two working days of signing the contract or delivered to the seller's business premises within that time.

If the purchase price of the goods or services was more than $50.00, and if delivery of the goods or payment was to be made in the future, then a written contract was required. The written contract had to contain:

1. the name and address of both the seller and the buyer;
2. a description of the goods and services sufficient to identify them with certainty;
3. an itemized price of the goods or services and a detailed statement of the terms of payment;
4. a statement of any secured credit that is involved;
5. full disclosure of the credit terms;
6. a statement of warranty or guarantee, if any;
7. the signatures of both parties.

Each party was entitled to an original signed copy of the contract.

There was a large loophole in the legislation as it did not apply to door-to-door sales where the goods were left with the consumer by the door-to-door salesman, and the price was paid in full by the consumer by way of cash, cheque or credit card. A person who purchased a vacuum cleaner for $5000 and paid for it on the spot by credit card was, therefore, not entitled to a cooling off period and not entitled to a written contract with the seller's name and address and other information.

Recent Changes to the Act

As of May 18, 2001, the 48 hour cooling off period is increased to a 10 day cooling off period for goods and services worth $50.00 or more that are NOT delivered at the time of the sale or paid for in full at the time of the purchase.

As of August 3, 2001, the 10 day cooling off period applies to all sales made at the consumer's home. The consumer may cancel the contract whether the goods are delivered or services are provided at the time of sale or afterwards, and regardless of whether payment is made in full or in part.

In addition, as of August 3, 2001, the information that a written contract must contain has been greatly expanded. The expanded requirements are listed under Ontario Regulation 175/01 as follows:

1. the buyer's name and address;
2. the seller's name, business address, telephone number, and, if any, fax number;
3. the name of the salesperson who entered into the contract on behalf of the seller;
4. the date and the place at which the parties entered into the contract;
5. a description of whatever goods or services are required by the contract that is sufficient to identify them;

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6. a statement, in not less than 12-point type, that the buyer has the rights set out in section 23.3 of the Act to cancel the contract;
7. the heading "Buyer's Right to Cancel" in not less than 12-point bold type proceeding the required statement;
8. If the statement setting out the buyer's right to cancel is not located entirely on the first page of the contract, a notice on the first page of the contract in not less than 12-point bold type indicating where in the contract this statement is located;
9. an itemized list of what portion of the contract price is attributable to each of the goods or services required by the contract;
10. the total amount of the contract price;
11. the terms of payment;
12. if the contract requires future delivery of goods, the date on which the goods will be delivered;
13. if the contract involves the delivery of services, the date on which the services are to be performed and completed;
14. detailed credit disclosure information;
15. detailed trade-in allowance information;
16. evidence of the signature of the parties to the contract.

The "Buyer's Right to Cancel" information must be in not less than 12-point bold type. The other information must be in not less than 10-point type.

In addition to the 10-day cooling off period, the buyer under a direct sales contract may cancel the contract within one year of the date of entering into the contract if the contract does not contain all of the information required. Furthermore, a buyer under a direct sales contract may cancel the contract within one year from the date of entering into the contract if (1) the seller does not deliver the goods required within 30 days of the delivery date specified in the contract, or (2) if the seller does not begin to provide the services required within 30 days of the commencement date specified in the contract.

The notice requirements for direct sales contracts are greatly improved. To cancel a direct sales contract, a buyer must give a notice of cancellation in any way, as long as it indicates the intention of the buyer to cancel the direct sales contract. The notice of cancellation may be given by any means, including personal service, registered mail, courier or telecopier or any other method by which the buyer can provide evidence of the date of cancellation of the direct sales contract. Where the notice is given other than by personal service, the notice of cancellation shall be deemed to have given when sent. A cancellation of a direct sales contract operates to cancel, as if it never existed, the contract, all sales related to the contract, all guarantees given, and all security given.

Within 15 days after the buyer cancels the direct sales contract, the seller must, subject to the regulations, refund to the buyer all money paid by the buyer and return to the buyer's address any trade-in goods or an amount equal to the trade-in allowance. The buyer must allow the seller a reasonable opportunity to repossess any goods that came into the buyer's possession under the contract.

The only exception to the cooling off period is in the case of emergency home repairs, where the consumer approaches the seller and requests that the services be provided within 10 days of receiving a written contract.

The direct sales initiative does not apply to mail order, telemarketing or Internet sales. It also does not apply to contracts negotiated or concluded at a marketplace, auction, trade fair or exhibition.

To make a complaint or to obtain further information, consumers can contact the Consumers Services Branch of the Ministry of Consumer and Business Services, at 1-800-268-1142 or 416-326-8611.

Legislation - *Patient Restraints Minimization Act* Becomes Law

By George T. Monticone

On June 29, 2001, the *Patient Restraints Minimization Act, 2001* became law in Ontario. The stated purposes of the Act are to: (1) minimize the use of restraints on patients; and (2) to encourage hospitals and facilities to use alternative methods, whenever possible, whenever it is necessary to prevent serious bodily harm by a patient to himself/herself or to others. It is doubtful that this Act achieves these purposes.

The Act is the outcome of debate and discussion that took place over a period of several months, originating with a private members bill, Bill 135, introduced by Frances Lankin, MPP for Toronto-Beaches. After encountering difficulties with the hospital caring for her mother, Ms Lankin was inspired to introduce a bill limiting the use of restraints on hospital patients. Remarkably for a non-government bill, Ms Lankin's bill, known as the *Public Hospitals Amendment Act (Patient Restraints), 2000*), received second reading and looked as though it had a reasonable chance of being passed into law. Public hearings were conducted in February of 2001. However, with the dissolution of the Legislature, Bill 135 was lost. In its place, we now have the *Patient Restraints Minimization Act, 2001*, S.O. 2001, c.16. While the purposes of the two pieces of legislation are similar, the new Act differs considerably from Bill 135.

The Act applies to public hospitals, hospitals licensed under the *Private Hospitals Act*, and to other facilities designated in regulations. Potentially, it could apply to long-term care facilities if these are appropriately designated in regulations.

When May Restraints Be Used?

The hospital/facility shall not restrain or confine a patient or use a monitoring device on a patient unless it is authorized to do so by the Act in either section 5 or section 6.

Section 5 of the Act permits a hospital/facility to restrain or confine a patient, or use a monitoring device on a patient if **four** conditions are met as follows:

(a) if it is necessary to prevent serious bodily harm to the patient or another person;
(b) if the restraint, confinement, or device is used in accordance with any requirements set out in regulations;
(c) if it gives the patient greater freedom or greater enjoyment of life; and
(d) if this is authorized by a plan of treatment to which either the patient or his or her substitute decision maker has consented.

A hospital/facility that believes a patient should be restrained must obtain the consent of the patient or substitute, and can only restrain if this gives the patient greater freedom or enjoyment. These requirements in section 5 are very patient-friendly and protect the patient from overzealous restraint, confinement, or monitoring.

However, section 6 of the Act permits a hospital/facility to restrain or confine, or use a monitoring device on a patient if only **two** conditions are met. These two conditions are identical to conditions (a) and (b) set out above.

The existence of both sections 5 and 6 in the Act, with nothing which says when one or the other of these sections applies, is most unusual. In effect, the patient protection found in subsections (c) and (d) of section 5 are rendered meaningless, since the patient may be restrained when (a) and (b) apply. Patients and their

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advocates will want to argue that all four conditions must apply, but a strict reading of these sections unfortunately does not justify this interpretation. However, patients and advocates may be successful in arguing that having regard for the entire Act, all four conditions must apply before a patient may be restrained, confined, or monitored. The argument would be that the purposes of the Act of minimizing restraining activities and encouraging alternatives can only be achieved by insisting that all four conditions apply.

Act Authorizes Hospitals to Restrain

It is noteworthy that while the Act clearly authorizes a hospital/facility to restrain, the predecessor Bill 135 did not do so. Bill 135 set clear limits on how and when to restrain, but no where said that a hospital/facility may restrain in certain circumstances. It may be argued that common law in Ontario does not authorize restraining a patient except in emergency situations when immediate action is required. Also, it may be argued that prior to this Act, nothing in Ontario statutes authorized a hospital/facility to restrain. If this is correct, then the *Patient Restraints Minimization Act, 2001* actually provides a license to restrain where none existed before. For those who believe that no restraining should be the norm in our hospitals and long-term care facilities, this is disappointing. A Canadian Charter of Rights and Freedoms challenge may be made to this legislation, since it may be argued that it discriminates against older persons or persons with disabilities by singling them out for special treatment.

The Act appropriately recognizes that there a number of means by which a person may be restrained including by the use of force, by mechanical devices such as straps and lap belts, by confining the person to a particular area, and by the use of chemicals. It also acknowledges that monitoring patients may be a form of restraining them. For example, if a patient is monitored and is detained when attempting to leave the hospital or facility, this clearly is restraining them. Until the *Patient Restraints Minimization Act, 2001*, there was no authority for a hospital or facility to do this without consent.

Lack of Procedural Protections in connection with the Use of Restraints

There is no mention in the Act of procedural protections for those whom a hospital/facility wishes to restrain. It may be argued that to avoid violations of the *Canadian Charter of Rights and Freedoms*, except in emergencies a person whom a hospital/facility wishes to restrain must be given advance notice, rights advice, access to legal counsel, and the opportunity for a fair hearing. While it is theoretically possible for a person being restrained to challenge this by bringing an *habeus corpus* application, if that person does not know this or cannot contact a lawyer for assistance, this right does them no good whatever. The Act should have ensured that patients would have the opportunity to obtain legal assistance if desired.

These procedural rights and protections are important. Persons charged with criminal offences, mental health patients, and those incapable of making decisions for themselves all have the benefit of statutory procedural rights (under the *Criminal Code*, *Mental Health Act*, *Health Care Consent Act*). It is most curious that persons in hospitals and facilities are not given the same rights.

Most of the Content of the Act Left to Regulations

Much of the impact of this Act will be found in regulations to be passed, since at present there is very little content in the Act.

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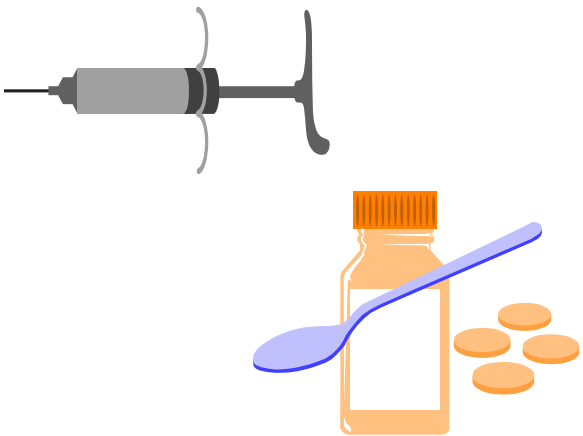
The Act requires hospitals/facilities to develop policies regarding restraining and monitoring if required to do so by regulation. The regulations may require that these policies be made available to the public. These provisions are not meaningful unless regulations are enacted.

The Act also requires a facility to restrain or monitor in accordance with regulations, and that patients being restrained or monitored be reassessed in accordance with regulations. Regulations may also require specific staff training, specific forms of record keeping, and may require that the hospital/facility report to specific persons. Again, these provisions of the Act are only meaningful if meaningful regulations are enacted.

Finally, while physicians are empowered to authorize restraining or monitoring, regulations may designate other classes of persons with this authority. Regulations may also prohibit standing orders for the use of restraints.

Lack of Remedies and Offences

There are two glaring omissions in the new Act. The Act does not define any offences, nor does it include any remedies such as fines or other sanctions for violating the provisions of the Act. Those who are improperly restrained, confined, or monitored can do nothing more than recite the prohibitions in the Act. In light of this, it is difficult to see how the Act assists patients in a concrete way.



Advance Care Planning Initiatives Delayed

The Spring 2001 *ACE Newsletter* contained an article about the Alzheimer Initiative Number 7 called "Advance Directives on Care Choices" that is an education project on advance care planning. It was reported that local Alzheimer Association chapters would offer public education sessions and an education programme for health care professionals beginning in the fall of 2001. We have recently learned that the education sessions will be rescheduled for the spring of 2002. Also delayed to the spring will be the distribution of a Guide to Advance Care Planning produced by the Ontario Seniors' Secretariat.

In the interim, if any groups of seniors or health care professionals are interested in education programmes on this topic in the fall of 2001, you may contact the Advocacy Centre for the Elderly. ACE offers speakers on this topic as well as on a wide range of legal topics related to seniors' issues, such as consent and capacity, elder abuse, mental health, seniors housing, and long-term care.

Bookings may be arranged by contacting Valerie Ella at 416-598-2656.

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The fee should be reasonable. Once the medical records have been requested, the clinical records clerk will pull the records. The records may be viewed in the clinical records department at the hospital. Requests for copies should be directed to the clinical records clerk.

Medical Records in a Psychiatric Facility

Special rules apply to medical records in a psychiatric facility. Under the *Mental Health Act*, there is a procedure for disclosure of the clinical record compiled in a psychiatric facility. A patient who is mentally competent is entitled to examine and copy at the patient's expense the clinical record of the patient or a copy of the record. The patient must make a written request to the officer in charge. The officer in charge on the advice of the attending physician may apply to the Consent and Capacity Board for authority to withhold all or part of the clinical record. A patient is entitled to notice of this application and the ground upon which it is based. The Consent and Capacity Board must review the clinical record within 7 days of receiving the application. The Board will allow the patient to examine the clinical record unless the Board is of the opinion that the disclosure of the clinical record is likely to result in:

a) serious harm to the treatment or recovery of the patient while in treatment at the psychiatric facility; or
b) serious physical harm or serious emotional harm to another person.

The patient and the attending physician may make submissions to the Board before it makes its decision. The Board may order that part of the clinical record not be disclosed. However,

the Board must specify in the order the ground under which disclosure is refused.

In cases where a patient is determined not to be mentally competent for the purpose of accessing the medical record, the patient may apply to the Board to review this finding. In the event that a patient is not mentally competent, the patient may appoint a representative to access the clinical record. The patient's substitute decision-maker is also entitled to examine or copy the patient's clinical record, in the event that the patient is not mentally competent.

Medical Records in a Long-Term Care Facility

All significant information about a resident in a long-term care facility is documented in the medical record. This includes identification of resident's needs, the plan of care, the care and services provided and the evaluation of care and services and the resident's care outcomes. The medical records in a long-term care facility contain detailed information about medications that have been prescribed to a resident. Each facility shall have written policies and procedures in relation to the records, including access by residents to their own records. A resident may wish to access their medical records for various reasons. For example, a resident may want to review his or her progress on a certain type of medication or a resident may want to obtain information about a course of treatment. The clinical record in a long-term care facility is owned by the facility but the information in the record belongs to the resident.

Regulations under the *Nursing Homes Act* state that only the individuals named in the regulations may inspect and receive information from a resident's medical or drug record and may reproduce and retain copies. The individuals listed in the regulations include the resident's attending physician or dentist, a member of the nursing staff or pharmacist in the

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nursing home, and the administrator of another nursing home to which the resident has been transferred. Individuals appointed by the Ministry of Health and Long-Term Care may also review records for specific purposes such as assessing and classifying residents, planning for future care and collecting information to determine the consistency and accuracy of information collected. The regulations specifically state that no person other than those described may inspect or receive information from a resident's medical or drug record and may reproduce copies. The regulations do not state that the resident, where capable or the resident's substitute decision-maker, where the resident is incapable, have a right to access and reproduce the clinical record. One possible interpretation of these regulations is that it limits access to the records to the essential individuals in the nursing home in order to protect the resident's private information. If the regulations are interpreted in that manner, they do not exclude the resident or the resident's substitute decision-maker from accessing the records. It is interesting that there are no corresponding regulations in the acts governing municipal or charitable homes for the aged.

The regulations relating to medical records in nursing homes may create barriers for nursing home residents attempting to access their medical records. Some nursing homes cite these regulations as a basis for denying access to medical records. This rigid interpretation of the regulations is contrary to the view taken by the Supreme Court of Canada in *McInerney*. However, other nursing homes regularly provide residents or their substitute decision-makers with access to the records. The regulations have not yet been challenged in a court of law. If these regulations are interpreted as prohibiting access to residents and their substitute decision-makers, there is a basis for a Canadian Charter of Rights challenge. An argument could be made that these regulations violate people's rights on the basis that they discriminate against elderly people. Residents or their substitute decision-makers should be encouraged to review their medical records in the nursing home, particularly so that they can make informed decisions about treatment.

The provincial government has talked about harmonizing the three separate acts relating to nursing homes, charitable institutions and municipal homes for the aged. While this has been discussed for several years, the government has not yet produced a draft of this legislation. Individuals who are concerned about the issues of access to clinical records in long-term care facilities should contact the Ministry of Health and Long-Term Care.

If you or your substitute decision-maker require access to the clinical record in a long-term care facility, you should make the request to the administrator of the nursing home in writing. If access is denied, you should ask the administrator to provide a written response stating the reason for the refusal. Residents and their substitute decision-makers should pursue this issue with the Ministry of Health and Long-Term Care and the local MPP.

Who to contact if you or your substitute decision-maker are having difficulties accessing medical records

If you or your legal representatives are having difficulties accessing your medical records, there are several steps you can take. If it is a problem involving medical records held by a physician, you should contact the College of Physicians and Surgeons of Ontario. If the problem relates to records in a hospital or long-term care facilities, contact the Ministry of Health and Long-Term Care. You may also want to contact your local MPP. In addition, you may wish to make a complaint to the Ombudsman. If you are encountering difficulties obtaining records in relation to a hearing before the Consent and Capacity Board, contact the Consent and Capacity Board ❁

The Abuse Education, Prevention and Response Project Is Available to Work with Your Community – Call Us!!

The Abuse Education, Prevention and Response Project sponsored by ACE and the Haldimand-Norfolk Project on the Abuse of Older Adults has been operating since January 2000 and will continue to December 2002. Funded by the Trillium Foundation, and managed by Joanne Preston, Project Coordinator, this project offers two types of workshops.

The first is a one day workshop that introduces participants to the issues related to elder abuse prevention and response, and details what is currently being done in Ontario and what resources are available to assist in abuse matters.

The second workshop involves four days of intensive training to assist a community in developing a Community Response Network to comprehensively address abuse of older adults ("Connecting Modules"). The Connecting Modules sessions are ordinarily conducted over a period of time rather than four days in a row.

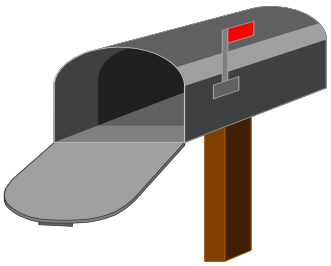
All costs related to the trainers (travel, accommodation, fees) are covered by the Project funding no matter where in Ontario the workshop is held. Expenses to the communities that would like the one day workshop or the four day training sessions are limited to advertising the event, reproduction of materials, the costs for the place to hold the session or sessions, AV rental, coffee/food provided at the workshops, and any other costs related to setting up the sessions.

Although the Project can offer the programmes in only a limited number of communities across the Province, there is still an opportunity to book either the one day or the four day sessions. ACE is particularly eager to offer the four day programme in an additional Northern Ontario community if one is interested. To date, workshops have been held in a variety of communities including Belleville, Brantford, Halton, Thunder Bay, Peterborough and Whitby/Oshawa, to name only a few.

For further information on this exciting project contact Joanne Preston at Site V, Box 36, RR#3, Port Dover, Ontario N0A 1N3
Phone (519) 583-2281
E-mail jpreston@nornet.on.ca
Website www.nornet.on.ca/~jpreston

Or contact Judith Wahl at the Advocacy Centre for the Elderly 416-598-2656

To: Joanne Preston



If you are not already a member of ACE, please consider joining. Benefits of membership include the ACE Newsletter, published twice a year, and voting privileges at the Annual General Meeting.

ADVOCACY CENTRE FOR THE ELDERLY*

2 Carlton Street, Suite 701, Toronto, Ontario M5B 1J3

APPLICATION FOR MEMBERSHIP

NAME: _____
(Individual/Corporate) Please Print

CORPORATE CONTACT (if applicable): _____

ADDRESS: _____ APT. _____

CITY: _____ POSTAL CODE: _____

TELEPHONE: (Home) _____ (Business) _____

Membership Fee:
(a) individual _____ $10.00 Enclosed
(b) corporate (agency, group) _____ $25.00 Enclosed

In addition to my membership fee, a donation of $_____ is enclosed.**

_____
Signature

Your membership is important. If the fee presents financial difficulties, please feel free to join anyway.

Committee Membership: I am interested in seniors' issues and would consider membership on an ACE Committee. Yes ____ No ____

Membership Expiry Date: Annual General Meeting, Fall 2002

By-Law No.1, 14.9 states: No owner or management official of a long term care facility, or employee of any organization representing long term care facilities shall be eligible to be elected to the Board of Directors of the Advocacy Centre for the Elderly.

* Holly Street Advocacy Centre for the Elderly Inc.
** A tax receipt will be issued for donations over $10.00.

E:\BOARD\AGM\MEM

1984 – 2001

17th
Annual General Meeting
Thursday, October 18, 2001
7:00 p.m.

Guest Speaker

Shirley Douglas
Spokesperson for the Canadian Health Coalition
Renowned Canadian Actress

The Privatization of the Canadian Health System

Please Join Us
at the
Toronto YMCA
20 Grosvenor Street
Auditorium, 2nd Floor
(2 blocks north of College between Yonge and Bay)

Everyone Welcome
Refreshments Will Be Served

For More Information Call ACE at 416-598-2656