First Nations and Inuit Health Branch (FNIHB)
Indian Residential Schools Resolution Health Support Program (IRS RHSP)
Missing and Murdered Indigenous Women and Girls (MMIWG)
Federal Indian Day Schools (IDS)

(ISC USE ONLY)	
Provider Number	Date

MENTAL HEALTH COUNSELLING APPOINTMENT CONFIRMATION

► **Please complete one form per client for sessions attended.**

Privacy Statement

The personal information you provide to the department is governed in accordance with the *Privacy Act* (https://laws-lois.justice.gc.ca/eng/acts/P-21/index.html). We only collect the information needed to administer the Indian Residential Schools Resolution Health Support Program, Missing and Murdered Indigenous Women and Girls and Federal Indian Day Schools. Collection of information for this purpose is authorized by statute. We require this information for the adjudication and payment of claims and for audit purposes. Your personal information may be disclosed without your consent, but only in accordance with subsection 8(2) of the *Privacy Act*. For more information: This personal information collection is described in Info Source at (https://www.aadnc-aandc.gc.ca/eng/1353081939455/1353082011520). In addition to protecting your personal information, the *Privacy Act* gives you the right to request access to and correction of your personal information. For more information, please contact the department's Access To Information and Privacy Coordinator. Contact information can be found at https://www.tbs-sct.gc.ca/ap/atip-aiprp/coord-eng.asp. You also have the right to file a complaint with the Privacy Commissioner of Canada if you think your personal information has been handled improperly.

Program Billed ► ☐ IRS RHSP ☐ MMIWG ☐ IDS | Prior Approval Number

Client Information

Given Name	Family Name
Parent or Legal Guardian Name (if applicable)	IRS RHSP Eligibility Number/IRSAS Verification Number (if available)

Provider Information

Provider Name (counsellor)		Business/Company Name	
Vendor Number (7-digit)	Invoice Number	Telephone Number	Email Address

NOTE ► The Client is not to be asked to sign the form in advance.

Date of Service (YYYY-MM-DD)	Start Time/ End Time	Duration/ Number of Hours Used	Modality of Session (Check One)	Client or Guardian Signature I acknowledge that I have received the counselling services indicated below (**Only sign after the session is complete**)		
	From: To:		◯ Face-to-Face ◯ Telephone/ Video-conferencing	Name	Signature	Date (YYYYMMDD)
	From: To:		◯ Face-to-Face ◯ Telephone/ Video-conferencing	Name	Signature	Date (YYYYMMDD)
	From: To:		◯ Face-to-Face ◯ Telephone/ Video-conferencing	Name	Signature	Date (YYYYMMDD)
	From: To:		◯ Face-to-Face ◯ Telephone/ Video-conferencing	Name	Signature	Date (YYYYMMDD)
	From: To:		◯ Face-to-Face ◯ Telephone/ Video-conferencing	Name	Signature	Date (YYYYMMDD)
	From: To:		◯ Face-to-Face ◯ Telephone/ Video-conferencing	Name	Signature	Date (YYYYMMDD)

IMPORTANT ► ISC reserves the right to request additional information as necessary.

Provider Signature	Date (YYYYMMDD)