SAMPLE CONSENT FORM

I, _____, hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medically related institution, my employer or other organization, institution or person that has any records or knowledge of my health and employment to give to _____ , union representative, Public Service Alliance of Canada, any such information and if deemed necessary, to secure a photographic copy of such information.

Signed _____

Address _____

_____

Telephone Number _____

Date _____

Name of Witness _____

Signature of Witness _____