

Administering Authority Letterhead

FAX COVER SHEET

INAC Children Out of the Parental Home Screening Consent

Date: _____

TO: Vancouver After Hours, Ministry of Children and Family Development

Phone Number: **604 660- 4927 or toll-free 1 800 663-9122**

Fax Number: **604 739-3741**

FROM: _____ (Worker's Name & Job Title)

_____ (Administering Authority Name)

Phone Number: _____

Fax Number: _____

Pages: _____ including this page

SUBJECT: Children Out of the Parental Home Screening Consent (COPH 02) form(s) for:

_____, _____, _____
(COPH Child's Last Name) (First and Middle Name) (Date of Birth yyyy-mmm-dd)

_____, _____, _____
(COPH Child's Last Name) (First and Middle Name) (Date of Birth yyyy-mmm-dd)

_____, _____, _____
(COPH Child's Last Name) (First and Middle Name) (Date of Birth yyyy-mmm-dd)

[NOTE: If there are more than one COPH child residing in the same household, list all the COPH children and attach the completed screening consent(s) for each child in the package]

Comments:

This package contains _____ completed screening consent form(s).
(# Count)

Please forward the result of the screening checks to: _____
(Print Name of Worker)

via email @ _____ or by mail to:
(Worker's secured email address)

(Address of the administering authority)

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