



Contact Preference Application Form

Office Use Only

Date Received:

Submission ID:

Processed By:

A contact preference is a document that allows an individual to specify if or how they want to be contacted by another party of the adoption. More information about contact preferences can be found [here](#).

The information on this form is collected under the authority of the *Adoption Act*, and the information will be used to fulfill the requirements of the *Act*.

Birth parents must complete and sign a separate contact preference for each child placed for adoption. Contact preferences do not apply to stepparent adoptions or adoptions that are finalized for those 18 years of age and older (adults).

Attach a clear copy of two current government-issued ID with your application (i.e. Driver's License, Passport, Birth Certificate, Health Card). If the copy is not clear, your contact preference application will not be processed and will be returned to you.

For questions:

Call: (902) 368-6139 or 1-844-982-0507 (toll free in North America)

Mail: Post-Adoption Services, P.O. 2000, 161 St. Peter's Road, Charlottetown, PE, C1A 7N8

Email: adoption@gov.pe.ca

All sections marked with an * must be completed; however, you are encouraged to complete all sections to the best of your knowledge and ability.

Applicant Information

All applicants must complete this section.

FIRST NAME*		MIDDLE NAME(S) *	CURRENT SURNAME*
PREVIOUS NAMES (I.E. MAIDEN NAME)		DATE OF BIRTH (DAY/MONTH/YEAR) *	
MAILING ADDRESS: APARTMENT NUMBER/STREET NAME AND NUMBER			
CITY/TOWN*	PROVINCE/STATE*	COUNTRY*	POSTAL/ZIP CODE*
MAIN TELEPHONE NUMBER* (INCLUDE AREA CODE)		ADDITIONAL TELEPHONE NUMBER(S) (INCLUDE AREA CODE)	
MAIN EMAIL ADDRESS*		CONFIRM EMAIL ADDRESS*	

The applicant is/ I am: An Adopted Person (18 Years Or Older) A Birth Parent

Section 1A: Adoption and Adoptee Information

Any applicant who is an adopted person (18 years or older) must complete this section.

NAME ON BIRTH CERTIFICATE <u>AFTER</u> ADOPTION*	DATE OF BIRTH (DAY/MONTH/YEAR) *
PLACE OF BIRTH*	PLACE OF ADOPTION (CITY/PROVINCE/STATE/COUNTRY) *
ADOPTIVE PARENT #1: FULL NAME AND DATE OF BIRTH*	ADOPTIVE PARENT #2: FULL NAME AND DATE OF BIRTH *
BIRTH REGISTRATION NUMBER (FROM BIRTH CERTIFICATE) *	

Section 1B: Birth Parent Information

Any applicant who is a birth parent must complete this section.

BIRTH PARENT INFORMATION AT TIME OF ADOPTED PERSON'S BIRTH	
BIRTH MOTHER'S FULL NAME*	BIRTH MOTHER'S DATE OF BIRTH* (DAY/MONTH/YEAR)
BIRTH FATHER'S FULL NAME*	BIRTH FATHER'S DATE OF BIRTH* (DAY/MONTH/YEAR)
ADOPTED PERSON INFORMATION PRIOR TO ADOPTION	
CHILD'S FULL NAME AT BIRTH*	
PLACE OF CHILD'S BIRTH	CHILD'S DATE OF BIRTH (DAY/MONTH/YEAR)

Section 1C: Contact Preference Service Request

All applicants must complete this section.

- Register a contact preference
 - If you have not submitted a contact preference in the past but want to submit one now, check this box and continue with the rest of the application.

- Modify a contact preference
 - If you have submitted a contact preference in the past but now want to modify it (i.e. to change how/if you are contacted), please check this box and continue with the rest of the application.

- Cancel a contact preference
 - If you have submitted a contact preference in the past but now want to remove it from your file, please check this box and continue with the rest of the application.

Date of previously submitted contact preference (if known or applicable):

_____ (Day/Month/Year)

Section 1D: Contact Preference Information

All applicants must complete this section.

CHECK THE BOXES OF THE TYPE(S) OF CONTACT YOU PREFER*

<input type="checkbox"/> No contact	<input type="checkbox"/> Contact at this telephone number by phone call:	<input type="checkbox"/> Contact at this telephone number by text message:
<input type="checkbox"/> Contact at this email address:		<input type="checkbox"/> Contact by another method (e.g. address for a written letter):

Section 1E: Contact Preference Declaration

All applicants must complete this section

By selecting either the “Register a Contact Preference,” “Modify a Contact Preference,” or “Cancel a Contact Preference” in Section 1C of this form, and checking the box below, I understand and acknowledge that:

- The other person will be notified of how or if I wish to be contacted.
- My contact preference does not prevent my name and other identifying information from being released.
- The Director will not release my name and other identifying information unless the other person has signed an undertaking acknowledging their intention to follow through with the terms of my contact preference.
- Post-Adoption Services cannot guarantee that the other person will follow through with the terms of my contact preference.
- I may modify or cancel my contact preference at any time by submitting a new contact preference to Post-Adoption Services.
- My contact preference will no longer be valid upon my death.
- When filing a ‘No Contact’ Preference, I am able to voluntarily provide a written statement of my current family social/medical background information, which Post-Adoption Services may share with the individual(s) I have identified.

By selecting this box, I _____ (*Full Name*) acknowledge that I have read and accept the terms outlined above, as of _____ (*Date; day, month, year*).

Section 2A: Medical History

This section is optional.

Please note: This section is optional and is not a requirement when filling out this application. If you decide to complete these sections, the information will be shared with the other party of the adoption. Please do not share information that you do not want disclosed.

Please check off all applicable boxes, and provide detailed explanations in the space provided on page 7.

When completing this section, you may wish to indicate: if you or a close family member experienced the medical issue, the age of the onset of the medical issue, and any other medical information you want to share.

Autoimmune Disorders

- Lupus
- Grave's disease
- Other (specify): _____

Birth Defects

- Club foot
- Cleft lip or cleft palate
- Down Syndrome
- Other (specify) : _____

Cancers

- Specify type and location, if known: _____

Dental Problems

- Orthodontia
- Other (specify): _____

Diseases of the Blood

- Sickle cell anemia
- Anemia
- Hemophilia
- Bleeding disorder
- Other (specify): _____

Diseases of the Circulatory System

- Rheumatic Fever
- Heart trouble
- High or low blood pressure
- Stroke
- Heart attack
- Other (specify): _____

Diseases of the Digestive System

- Stomach, liver or intestines
- Gall bladder or gallstones
- Other (specify): _____

Diseases of the Nervous System

- Multiple Sclerosis (MS)
- Tremors
- Seizures, convulsions, epilepsy
- Other paralysis or crippling disorder
- Other (specify): _____

- Diseases of the Respiratory System**
 - Sinusitis
 - Hay fever/other allergies
 - Asthma
 - Tuberculosis, emphysema
 - Chronic respiratory disease
 - Cystic Fibrosis
 - Other (specify): _____
- Diseases of the Skin**
 - Eczema
 - Dermatitis
 - Psoriasis
 - Other (specify): _____
- Diseases of the Urinary System**
 - Kidney or bladder disorder
 - Other (specify): _____
- Disorder of the Bones/Connective Tissue**
 - Arthritis, rheumatism or bursitis
 - Scoliosis
 - Bone, joint or other deformity
 - Other (specify): _____
- Disorders of the Muscles**
 - Muscular Dystrophy
 - Muscle weakness
 - Other (specify): _____
- Disorder of the Sense Organs**
 - Color blindness
 - Night blindness
 - Glaucoma
 - Hearing loss/deafness
 - Other (specify): _____
- Endocrine and Metabolic Disorders**
 - Diabetes
 - Thyroid
 - Other (specify): _____
- Infectious Diseases**
 - Sexually transmitted diseases
 - HIV/AIDS
 - Other (specify): _____
- Mental Health and Addictions**
 - Depression
 - Bipolar
 - Anxiety
 - Psychotic Disorder, Schizophrenia
 - Substance Use/Abuse
 - Other (specify): _____

Pregnancy and/or Childbirth Complications

- Premature births, miscarriage
- Stillbirths
- Multiple births
- Infant death and/or SIDS
- Gestational Diabetes
- Other (specify): _____

Reproductive Health Issues

- Endometriosis
- Polycystic ovarian syndrome
- Menstrual disorders
- Prostate gland disorders
- Other (specify): _____

Additional Medical History Information

Use the space below, or attach an additional document to this application, with more detailed information about your medical history.

Section 2B: Written Statement

This section is optional.

Please note: This section is optional and is not a requirement when filling out this application. If you decide to complete these sections, the information will be shared with the other party of the adoption. Please do not share information that you do not want disclosed.

You may complete the following sections in the space below, or by attaching an additional document to this application.

Would you like to share why you are submitting a “no contact” preference?

Is there any additional non-identifying personal, family history or social information you wish to disclose?

Final Checklist

All applicants must complete this section.

Please read the following information and terms below. For your application to be processed, you must select the box, type in (or sign) your full name, and include the date (see below).

- As the applicant, I understand that I must complete the mandatory sections before my application will be processed. I understand that these mandatory sections include:
 - Completing the “applicant information” section (pg. 1)
 - Indicating if I am an adult adopted child (adoptee) or a birth parent (pg. 2)
 - Completing the mandatory areas (*) in section 1 (pgs. 2 and 3)
 - Reading and accepting the terms within the declaration (pg. 4)
 - Including two pieces of ID with my application (such as a driver’s license, health card, passport or a birth certificate)
 - Reading and accepting the terms within the final checklist (p. 10)
- As the applicant, I understand that Section 2 of the form (medical conditions and written statement sections) are optional, but encouraged to be completed. I understand that if I completed these sections, the information will be shared with the other party of the adoption (i.e. birth parent or adult adoptee).
- As the applicant, I acknowledge that the information that I have included within this application is true, and has been completed to the best of my knowledge and ability.

By selecting this box, I _____ (Full Name) acknowledge that I have read and accept the terms outlined above, as of _____ (Date; day, month, year).

Your completed application can be submitted by:

Mail
Post-Adoption Services
P.O Box 2000
161 St. Peter’s Road
Charlottetown, PE, Canada

Email
adoption@gov.pe.ca