THE SDRC THE SEPARATION & DIVORCE RESOURCE CENTRE INC.
110 Bearbrook Rd., Suite 2B, Ottawa, ON K1B 5R2
www.thesdrc.com | info@thesdrc.com | 613 837 9025
Rebuilding Relationships

SUPERVISED VISIT APPLICATION FORM

For further information or help completing this form, contact the Program Coordinator
Tarah Sly at 613-837-9025 or tarah@thesdrc.com

APPLICANT INFORMATION

First Name:_____ Last Name:_____

☐ Male ☐ Female ☐ Other

Relationship to child(ren):

_____

Street Address:

_____

City: Province: Postal Code:

_____ _____ _____

Home Phone: Cell Phone:

_____ _____

Work Phone: Email:

_____ _____

First Name of other parent/guardian: Last name of other parent/guardian:

_____ _____

☐ Male ☐ Female ☐ Other

Relationship to child(ren):

_____

APPLICANT'S LAYWER INFORMATION

First Name of lawyer: Last name of lawyer:

_____ _____

Street Address:

_____

City: Province: Postal Code:

_____ _____ _____

Work Phone: Fax:

_____ _____

Email:

_____

EMERGENCY CONTACT INFORMATION

First name of 1st emergency contact: Last name of 1st emergency contact:

_____ _____

Relationship:

_____

Home Phone: Work Phone: Cell Phone:

_____ _____ _____

First name of 1st emergency contact: Last name of 1st emergency contact:

_____ _____

Relationship:

_____

Home Phone: Work Phone: Cell Phone:

_____ _____ _____

APPLICANT MARITAL STATUS

Check all that apply:

☐ Single

☐ Separated Date of separation (dd-mm-yyyy):_____

☐ Divorced Date of divorce (dd-mm-yyyy): _____

☐ Common law

☐ Remarried

First name of current spouse/partner: Last name of current spouse/partner:

_____ _____

CUSTODY AND ACCESS:

With whom do the child(ren) reside:

_____

Custody:

☐ Mother ☐ Father ☐ Joint ☐ Other

Have there been previous visit arrangements? (check all that apply)

☐ Previous unsupervised access ☐ Previous supervised access

☐ No previous access ☐ Other:_____

If there have been previous access arrangements, please provide the details, in chronological order, from earliest to most recent:

1. Access arrangement location: Dates:

From: To:

_____ _____ _____

Was the access supervised? ☐ Yes ☐ No

If the access was supervised, by whom? Reason for termination:

_____ _____

2. Access arrangement location: Dates:

From: To:

_____ _____ _____

Was the access supervised? ☐ Yes ☐ No

If the access was supervised, by whom? Reason for termination:

_____ _____

3. Access arrangement location: Dates:

From: To:

_____ _____ _____

Was the access supervised? ☐ Yes ☐ No

If the access was supervised, by whom? Reason for termination:

_____ _____

How long has it been since the last visit (specify number under most appropriate category):

_____ Weeks _____ Months _____Years

SERVICES REQUESTED

The Separation/Divorce Resource Centre Inc. only provides supervised access

How were you referred to our service?

- ☐ Court Ordered
- ☐ Court recommended
- ☐ Lawyer
- ☐ Mediation
- ☐ Office of the Children's Lawyer
- ☐ Self-referral
- ☐ Other:_____

Do you agree with the referral? ☐ Yes ☐ No

Is there a court order specifying supervised access? ☐ Yes ☐ No

Are there ongoing legal proceedings? ☐ Yes ☐ No

Is there a civil, criminal or immigration trial pending? ☐ Yes ☐ No

If there is a trial pending please provide details:

_____

_____

Are there any No Contact or Restraining Orders, ect? ☐ Yes ☐ No

Are you subject to Probation Order, Probation Recognizance or Community Supervision Order?

☐ Yes ☐ No

Is the other party subject to Probation Order, Probation Recognizance or Community Supervision Order? ☐ Yes ☐ No

If applicable, do you give the SDRC INC. consent to speak with your probation officer regarding their involvement? ☐ Yes ☐ No

Signatue:_____ Date:_____

Please print name:_____

CHILDREN'S INFORMATION:

1. First name: **Last Name:**

_____ _____

☐ Male ☐ Female Date of Birth (dd-mm-yyyy):_____

Health card number:_____

Physicians Name: Physicians number:

_____ _____

Special needs/allergies/behavioural problems

_____

2. First name: **Last Name:**

_____ _____

☐ Male ☐ Female Date of Birth (dd-mm-yyyy):_____

Health card number:_____

Physicians Name: Physicians number:

_____ _____

Special needs/allergies/behavioural problems

_____

3. First name: **Last Name:**

_____ _____

☐ Male ☐ Female Date of Birth (dd-mm-yyyy):_____

Health card number:_____ _ _____

Physicians Name: Physicians number:

_____ _____

Special needs/allergies/behavioural problems

_____

What languages are spoken at home? (check all that apply)

☐ English ☐ French ☐ Other:_____

If your child works with the Office of the Children's Lawyer, provide the details about the child(ren)'s representative:

First Name: Last Name:

_____ _____

Type of representative:

☐ Lawyer ☐ Social Worker ☐ Other:_____

Phone number: _____

CHILDREN'S AID INVOLVEMENT

Has any of the children's aid society been involved with your immediate family?

☐ Yes ☐ No

If yes, concerning whom? Name of children's aid society:

_____ _____

First name of case worker: Last name of case worker:

_____ _____

Phone number of case worker:_____

What were the concerns of the children's aid society?

☐ Neglect ☐ Emotional/psychological abuse

☐ Physical abuse ☐ Sexual abuse

☐ Other:_____ _____

Did the children's aid conduct and investigation?

☐ Yes ☐ No

If yes, what was the result of their involvement?

_____

Is the children's aid still involved with your family?

☐ Yes ☐ No

If yes, in what capacity are they involved?

☐ Working voluntarily with the family

☐ Working with the family under ac ourt or supervision order

☐ Providing a foster or residential care for the child(ren)

Have any of the children ever been places in the care of a children's aid society?

☐ Yes ☐ No

If yes, when (dd-mm-yyyy):_____

If yes, please specify:

☐ Voluntarily

☐ Under a court order for society wardship

☐ Under a court order for crown wardship

If the Children's Aid Society is involved with your family, complete the following release of information:

RELEASE OF INFORMATION

I, _____ give my permission to the Children's Aid Society to release information about the status of CAS involvement with myself and family to the Separation/Divorce Resource Centre Inc. in order to determine eligibility for service.

CHILD(REN)'S NAME AND BIRTH DATES:

1. First name of child: Last name of child:

_____ _____

Date of birth (dd-mm-yyyy):_____

2. First name of child: Last name of child:

_____ _____

Date of birth (dd-mm-yyyy):_____

3. First name of child: Last name of child:

_____ _____

Date of birth (dd-mm-yyyy):_____

4. First name of child: Last name of child:

_____ _____

Date of birth (dd-mm-yyyy):_____

_____ _____

Parent signature Date

Promise to The SDRC Inc.

I, _____, swear that I have not knowingly hidden or withheld any legal reports, documents, court orders, or relevant legal or medical information from The SDRC Inc. staff.

I, _____, swear that if there are any new motions, court orders, CAS investigations, police reports, assessments or any other new medical or legal documents pertaining to the parents and children in this file, I will provide notice and a copy of the documentation to The SDRC Inc. within 3 business days.

_____ _____

Signature Date