# CERTIFICATE OF RESULTS
## COVID-19 Rapid Antigen Test

### PATIENT INFORMATION

**Name:**

**Date of Birth:**

**Address:**

**Address:**

**Phone Number:**

**Email:**

**Healthcard Number (if applicable):**

**Province of Issue:**

**Other Photo ID provided:**

### TEST INFORMATION

**Name of Test Conducted:**

**Specimen Type:**

**Collection Date:**

**Time:**

**Test Type:**

**Sensitivity, Specificity:**

**Health Canada Authorization #:**

**Lot #/Expiration Date:**

**Result:**

### TESTING LOCATION

**Pharmacy Name:**

**Phone Number:**

**Pharmacy Address:**

**Name of Pharmacy Practitioner:**

**Signature of Pharmacy Practitioner:**

**License #**