Ontario
eHealth Ontario

OLIS-EMR Client Information Form

Date:

Form Completion Instructions

- **Please complete all fields as specified (indicate "N/A" if a field is not applicable)**
- **Please type directly into the Client Information Form (CIF)**
- **Once completed, please save the form and email to OntarioMD at support@ontariomd.com**
- **If you are a Family Health Team, Family Health Group, Family Health Organization, Family Health Network or Primary Care Network, please provide the organization name that you've used in the funding agreement(s) with the Ministry of Health and Long-Term Care**
- **If you are a Sole Practitioner Medicine Professional Corporation, please provide the corporation name**

1. Organization Information:

Organization Name (see note above re practices):	
Name change or restructuring in the last eight years?	**Yes ☐ No ☐**
For name change, please provide previous name:	
For Organization restructuring, please provide summary of structure change (*e.g., merger or acquisition*):	
Affiliated LHIN:	

2. Address of Practice Group[1]:

Building Address (*number and street name*):		**Suite Number (*if applicable*):**	
Building Name (*for multi-building sites*):		**Business Telephone:**	
City/Town:		**Postal Code:**	

3. a) Is the Organization identified in Section #1 above a health information custodian (HIC) within the meaning of the *Personal Health Information Protection Act, 2004* (PHIPA)? Yes ☐ No ☐

b) Please indicate the applicable organization type below:

Family Health Group	☐	**Family Health Organization**	☐	**Primary Care Network**	☐
Family Health Network	☐	**Family Health Team**	☐	**Sole Practitioner or Physician Group Practice**	☐
Other (*please specify*)	☐				

c) If the Organization identified in Section #1 above has more than one facility or location, or operates within or is affiliated with another organization, please list all below:

Facility/location or other organization name	Address	Is this facility/ location a separate legal entity?	Is this facility/location a separate health information custodian (HIC)?
		Yes ☐ No ☐	Yes ☐ No ☐
		Yes ☐ No ☐	Yes ☐ No ☐
		Yes ☐ No ☐	Yes ☐ No ☐

[1] Each "Practice" or "Physician Group" must (a) be owned by one or more physicians or nurse practitioners (b) must use a single EMR (if applicable) and (c) have access to each other's paper or electronic patient records. A Physician Group or Practice may be one of the following:

i. A Ministry of Health and Long-Term Care (MOHLTC) primary care group such as a Family Health Network (FHN), Family Health Organization (FHO), Rural Northern Physician Group Agreement (RNPGA), Primary Care Network (PCN), Family Health Group (FHG), and Family Health Team (FHT).

ii. A sole practitioner that practices by himself or herself. Note: A sole practitioner who participates in a MOHLTC-funded primary care group must apply and participate through that group.

iii. Organizations or entities that operate clinics where physicians or nurse practitioners conduct medical practices, including the primary organization that a sole practitioner, or group of sole practitioners:

a. own(s) and/or is responsible for the operations; or

b. contracts with in order to practice medicine.

***Note*: If any facilities, locations or organizations listed above are a separate health information custodian (HIC), a separate CIF and agreement may**

be required for each.

4. Legal status of the Organization identified in Section #1 above (*check all that apply*):

Registered under the *Business Names Act* (Ontario)	☐
Partnership under the *Partnerships Act* (Ontario)	☐
Limited partnership under the *Limited Partnerships Act* (Ontario)	☐
Corporation under the *Business Corporations Act* (Ontario)	☐
Corporation under the *Corporations Act* (Ontario)	☐
Corporation under the *Not-for-profit Corporations Act* (Ontario)	☐
Medicine Professional Corporation under the *Business Corporations Act* (Ontario)	☐
Other (*please specify*):	

5. Signing Authority (*person with authority to sign on behalf of the Organization identified in Section #1 above*):

Salutation Dr. ☐ Mr. ☐ Ms. ☐ Mrs. ☐ Miss. ☐	**First Name:**		**Last Name:**	
Job Title:				

6. Lead Practitioner and/or Authorized Representative (*contact for general inquiries*):

Salutation Dr. ☐ Mr. ☐ Ms. ☐ Mrs. ☐ Miss. ☐	**First Name:**		**Last Name:**	
Job Title:				
Phone Number:		Ext.	**Fax Number:**	
Email Address:				

7. Privacy Officer or delegate (*contact for notices on privacy matters*):

Salutation Dr. ☐ Mr. ☐ Ms. ☐ Mrs. ☐ Miss. ☐	**First Name:**		**Last Name:**	
Job Title:				
Phone Number:		Ext.	**Fax Number:**	
Email Address:				

8. System Security Contact (*contact for notices on security matters*):

Salutation Dr. ☐ Mr. ☐ Ms. ☐ Mrs. ☐ Miss. ☐	**First Name:**		**Last Name:**	
Job Title:				
Phone Number:		Ext.	**Fax Number:**	
Email Address:				

9. Practice Technical/IT Lead Name and Contact (Please provide the name of a technical contact who provides support for this services at the Practice Location):

Salutation Dr. ☐ Mr. ☐ Ms. ☐ Mrs. ☐ Miss. ☐	**First Name:**		**Last Name:**	
Job Title:				
Phone Number:		Ext.	**Fax Number:**	
Email Address:				

10. If the Organization identified in Section #1 above is requesting access to EHR services, indicate below all applicable activities:

Health care means any observation, examination, assessment, care, service or procedure that is done for a health-related purpose and:	
➢ **that is carried out or provided to diagnose, treat or maintain an individual's physical or mental condition**	☐
➢ **that is carried out or provided to prevent disease or injury or to promote health**	☐
➢ **that is carried out or provided as part of palliative care**	☐
➢ **includes the compounding, dispensing or selling of a drug, a device, equipment or any other item to an individual, or for the use of an individual, pursuant to a prescription**	☐
➢ **includes a community service that is described in subsection 2 (3) of the Home Care and Community Services Act, 1994 and provided by a service provider within the meaning of that Act; ("soins de santé")**	☐

If the Organization identified in Section #1 does <u>not</u> provide health care services as defined above, please list the services provided (*Note: If you are not providing 'health care', you will not be eligible to access EHR services*):

11. Please indicate the types of roles/staff employed/contracted by the organization identified in Section #1 above (*check all that apply*) and the types of roles/staff within the organization that will require access to eHealth Ontario services (*check all that apply*):

	Number employed/contracted by your organization	**Require access to eHealth Ontario services**
Physicians	☐	☐
Nurses	☐	☐
Nurse Practitioners	☐	☐
Allied Healthcare Professionals	☐	☐
Administrative Staff	☐	☐
Other (*please specify all*):		

12. Vendor Information (Please provide the EMR Vendor and Software information used at this Practice):

EMR Vendor:		**EMR Software and Version Number:**	

13. Contact Information (Please provide the name and email address of the person who completed and submitted the form to eHealth Ontario):

Form Submitted by:		**Business E-mail:**	

For Internal eHealth Ontario Use Only			
Date Received:		**Authorized Contact Setup Date:**	
Unique Instance Identifier Assigned:		**OLIS Configuration Setup Date:**	
Certificate Information:	☐ **ASP** ☐ **Local**		

Appendix			
Clinician First Name	**Clinician Last Name**	**Clinician Title**	**CPSO / CNO #**