eCHN Portal Access Application Form

Form C: User Registration for Applicants from an Existing eCHN Client Version 3.0 (November 12, 2018)

Application Form Instructions

There are different application forms for access to the eCHN Portal depending on what type of entity the applicant is.

This form initiates the application process for an individual user applicant working at an existing eCHN Client, i.e.:

- an employee of an existing eCHN Healthcare Organization Client (i.e., hospital, LHIN, or healthcare practice that operates as a single health information custodian),
- a physician at an existing eCHN Healthcare Organization Client (i.e., having privileges at a hospital Client, or an affiliation with a healthcare practice that operates as a single health information custodian).
- an employee of an existing eCHN Solitary Healthcare Practitioner Client.

If you are unsure if the organization/practice you work at is an existing eCHN Client, please call the eCHN Help Desk at 416-813-7998.

If you are an individual user applicant working at an existing eCHN Client, please complete Parts 1, 2 and 3. All fields are mandatory unless indicated otherwise. This form must be co-signed by a signing authority of the existing eCHN Client you work at.

Upon approval of your application, eCHN will issue login credentials. The first time you login, you must execute an online agreement containing the eCHN Terms and Conditions.

Submit your completed form to the eCHN Help Desk by fax: 416-813-8294 or email: helpdesk@echn.ca.

Part 1 – User/Applicant Information

Salutation Dr.☐ Mr.☐ Miss☐ Mrs.☐ Ms.☐	First Name	Last Name
Name of existing eCHN Healthcare Organization Client or Solitary Healthcare Practitioner Client		
Address of existing eCHN Healthcare Organization Client or Solitary Healthcare Practitioner Client (Street and City)		
Province and Postal Code	Business Telephone *(incl. Extension)*	Business E-mail
Please indicate your Job Title:	Professional College License Number, or N/A (e.g. CPSO, CNO, etc.):	

Please indicate your professional role with the existing eCHN Client:

☐ Staff Physician: Admitting Privileges: ☐ Yes ☐ No

☐ Fellow/Resident/Locum *(Please include start/end date below)*
Start Date: _____ End Date: _____

☐ Allied Health Professional *(Please indicate Role):*
_____

☐ Other *(Please indicate Role):*
_____

☐ Nurse (*Please indicate RN, RPN, NP)*
_____

☐ Technologist

☐ Administrative Staff *(Please indicate Role):*
_____

☐ Health Records

Part 2 – Access Type

Please indicate which eCHN Portal functionality you are requesting access to (see below for descriptions):

☒ **WebChart *and* eReferral** [Note: this option is not available to Users located outside of Ontario]

☐ **eReferral Only**

Descriptions:

- **WebChart**: WebChart provides access to the pediatric records in the eCHN repository which includes data from over 70 Ontario hospitals and other health information custodians.

- **eReferral:** eReferral provides a gateway to various patient referral applications hosted by third party eReferral Clients.
  - eCHN will share the registration details provided on this form with third party eReferral Clients to facilitate a seamless referral experience.
  - eReferral includes a delegation tool which permits healthcare practitioner Users to delegate submission and tracking of e-Referrals on their behalf to other authorized eCHN Users (e.g., admin, Locum Physician, etc.)

Part 3 – Authorization

User Agreement:

As the individual user applicant identified in Part 1, I confirm that the statements made in this Application are accurate and true. I acknowledge that as a condition of being granted access to the eCHN Portal, upon my first login I must execute an online agreement to certify that I have read, understand and agree to comply with the eCHN Terms and Conditions as they apply to me as an eCHN User.

User Signature _____ Date _____

Existing eCHN Client Authorization:

By signing below, I certify that I am an authorized signing authority at the existing eCHN Client identified in Part 1 (or the Client's Local Registration Authority (LRA) on file with eCHN), and I confirm that the individual user applicant identified in Part 1 is authorized to have access to the eCHN Portal on behalf of such eCHN Client, in accordance with the eCHN Terms and Conditions, which the eCHN Client must separately execute. I acknowledge that I have read, understand and agree to comply with the eCHN Terms and Conditions.

Name (please print) _____ Date _____

Signature _____

Name of Healthcare Organization Client _____ OR College License Number (If you are a Solitary Healthcare Provider Client) _____

Submit the completed application to:
eCHN Help Desk
Fax: 416-813-8294 or Email: helpdesk@echn.ca
If you have any question, please contact us at:
Phone: 416-813-7998, Toll Free: 1-877-252-9900