eCHN Portal Access Application Form

# Form B: New Solitary Healthcare Practitioner Client Registration

Version 4.0 (April 20, 2019)

## Application Form Instructions

There are different application forms for access to the eCHN Portal depending on the type of the applicant's organizational structure.

This form initiates the application process for a **Solitary Health Care Practitioner, as defined below**.

**"Solitary Healthcare Practitioner"** means a regulated healthcare practitioner operating his/her own practice and accountable as a single health information custodian (as that term is defined in Ontario's *Personal Health Information Protection Act* (PHIPA) for all employees working at the practice.

If you are a Solitary Healthcare Practitioner, please complete **all parts** and submit it to the eCHN Service Desk. **All fields are mandatory unless indicated otherwise.**

The eCHN Service Desk will contact you with the next steps in the application process. **Note:** if you have any administrative or support staff who wish to access the eCHN Portal on your behalf, they must each complete a separate eCHN Portal Access Application (Form C) to obtain their own login credentials. The eCHN Service Desk can guide you through that process.

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

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

## Part 1 – Solitary Healthcare Practitioner Applicant Details

**Business Name that your practice operates under (if different than your name):**

| | | |
|---|---|---|
| **Salutation: Dr. Mr. Miss Mrs. Ms.** | **First Name** | **Last Name** |

| | | |
|---|---|---|
| **Practice Address (Number and Street)** | **City and Province** | **Postal Code** |
| **Telephone (incl. Extension):** | **E-mail:** | |
| **Fax:** | **Professional Role (Physician, Optometrist, etc.):** | |
| **Professional College License Number (e.g. CPSO, CNO, etc.):** | **Ontario Billing Number (*if applicable*):** | |

**Go to Part 2 (pg. 2)**

## 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]

**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

### Solitary Healthcare Practitioner Agreement:

As the applicant identified in Part 1, I confirm that the statements made in this eCHN Portal Access Application Form are accurate and true. By signing below, I am submitting this application in my personal capacity. I acknowledge that as a condition to 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.

_____

Solitary Healthcare Practitioner Signature ***(eSignature NOT accepted)***

_____

Date

Submit the completed application to:
**eCHN Service 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

eCHN Portal Access Application Form

# Form C: User Registration for Applicants from an Existing eCHN Client

Version 4.0 (May 5, 2019)

## Application Form Instructions

There are different application forms for access to the eCHN Portal depending on what type of the type of the applicant's organizational structure.

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 Service Desk at 416-813-7998.

If you are an individual user applicant working at an existing eCHN Client, **please complete all parts**. 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 Service Desk by fax: 416-813-8294 or email: helpdesk@echn.ca.

## Part 1 – Solitary Healthcare Practitioner Applicant Details

**Business Name that your practice operates under (if different than your name):**

| **Salutation:** Dr. Mr. Miss Mrs. Ms. | **First Name** | **Last Name** |
|---|---|---|
| **Practice Address (Number and Street)** | **City and Province** | **Postal Code** |
| **Telephone (incl. Extension):** | **E-mail:** | |
| **Fax:** | **Professional Role** (Physician, Optometrist, etc.): | |
| **Professional College License Number** (e.g. CPSO, CNO, etc.): | **Ontario Billing Number** (*if applicable*): | |

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 ***(eSignature NOT accepted)*** 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 ***(eSignature NOT accepted)***

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