



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 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 at helpdesk@echn.ca or via fax at 416-813-8294. **All parts are mandatory** unless indicated otherwise.

If you have any **administrative or support staff** who you wish to have access to the eCHN portal on your behalf, they must each complete a separate eCHN portal Access Application (Form C) to obtain their own login credentials. You may indicate this requirement in **Part 3** of this form.

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](#).

Part 1 – Solitary Healthcare Practitioner Applicant Details

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

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

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 – Supporting Staff Delegation Confirmation (optional)

Please complete the below information as well as the eCHN portal functionality required for each supporting staff accessing the eCHN portal on your behalf within the **same practice**. The individual will also be required to submit Form C.

Once approved, the eCHN service desk will create the delegation within the system on your behalf. Any changes to the delegation function can be changed at any time by logging into the eCHN portal and selecting the Delegation tab from the main menu.

First Name	Last Name	Access Required (see Part 2 for description of eCHN Portal Applications)
		<input type="checkbox"/> WebChart <input type="checkbox"/> eReferral <input type="checkbox"/> Both WebChart & eReferral Exp. Date: YYYY/MM/DD <i>(if applicable)</i>
		<input type="checkbox"/> WebChart <input type="checkbox"/> eReferral <input type="checkbox"/> Both WebChart & eReferral Exp. Date: YYYY/MM/DD <i>(if applicable)</i>
		<input type="checkbox"/> WebChart <input type="checkbox"/> eReferral <input type="checkbox"/> Both WebChart & eReferral Exp. Date: YYYY/MM/DD <i>(if applicable)</i>
		<input type="checkbox"/> WebChart <input type="checkbox"/> eReferral <input type="checkbox"/> Both WebChart & eReferral Exp. Date: YYYY/MM/DD <i>(if applicable)</i>

Part 4 – 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
(e-signature not accepted)

Date

Submit the completed application to eCHN Service Desk: Fax: 416-813-8294 or Email: helpdesk@echn.ca