eCHN Portal Access Application Form

Form E: eReferral Client or User Registration

Version 4.0 (April 1, 2020)

Application Form Instructions

This form initiates the application process for healthcare practitioners and their authorized delegates to access the eCHN Portal for the purpose of using the eReferral Gateway. The eReferral Gateway permits access to an external patient referral application ("External Referral Application") maintained by a hospital wishing to receive patient referrals electronically ("eReferral Hospital").

Please note: eCHN will share the registration details provided on this form with third party eReferral Hospitals to facilitate a seamless referral experience.

EACH APPLICANT MUST COMPLETE A **SEPARATE APPLICATION** IN ORDER TO HAVE AN INDIVIDUAL ACCOUNT WITH eCHN TO ACCESS THE eREFERRAL GATEWAY.

IF YOU ARE A NEW **HEALTHCARE PRACTITIONER APPLICANT**, PLEASE FILL OUT **PARTS 1 AND 2 ONLY** TO APPLY FOR ACCESS AS AN eREFERRAL CLIENT.

IF YOU ARE A **NEW ADMINISTRATIVE STAFF APPLICANT**, PLEASE FILL OUT **PART 3 ONLY** TO APPLY FOR DELEGATED ACCESS AS AN AUTHORIZED USER AND HAVE THE **AUTHORIZING HEALTHCARE PRACTITIONER** FILL OUT **PART 4 ONLY**.

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

NOTE: Before an authorized User can access eReferral Gateway, the authorizing eReferral Client must also delegate referral rights online within the eCHN Portal.

NOTE: If you are applying for access to eCHN eReferral from outside of Ontario, your use of eCHN eReferral must comply with the privacy legislation in your province that protects personal health information and limits its collection, use and disclosure. For further clarity, by agreeing to the eCHN Terms & Conditions referenced above, where obligations under Ontario privacy legislation are referenced therein, you are required to comply with the equivalent obligations under the privacy legislation in your province.

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

Part 1 – HealthCare Practitioner Applicant Information

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*):	

Part 2 – Healthcare Practitioner Applicant Signature

As the person identified in Part 1, I confirm that the statements made in this eCHN Portal Access Application Form are true and correct. I acknowledge that I have read, understand and agree in my personal capacity to comply with the eCHN eReferral Terms and Conditions as they apply to me as an eReferral Client (as set out in the eReferral Terms and Conditions).

Applicant Signature ***(eSignature NOT accepted)*** Date

Part 3 –Administrative Staff Access

(NOTE**:** The authorizing Healthcare Practitioner Applicant must delegate referral rights to Administrative Staff within the eCHN system or may authorize the eCHN Helpdesk to do so on his/her behalf).

Salutation: Dr. ◯ Mr. ◯ Miss ◯ Mrs. ◯ Ms. ◯	First Name	Last Name
Organization/Office Name		
Organization/Office Address (Street)	City and Province	Postal Code
Telephone *(incl. Extension)*	E-mail	
Please indicate your Job Title:		

As the person identified above in Part 3, I confirm that the statements made in this eCHN Portal Access Application Form are true and correct. I acknowledge that I have read, understand and agree in my personal capacity to comply with the eCHN eReferral Terms and Conditions as they apply to me as a User (as set out in the eReferral Terms and Conditions).

Applicant Signature ***(eSignature NOT accepted)*** Date

Part 4 - Healthcare Practitioner Authorization of Administrative Staff Application and *(optional)* Delegation Authorization

As the authorizing and referring licensed healthcare practitioner, I confirm that the statements made in this form are true and correct. I certify that the delegated User identified in Part 3 is authorized to act on my behalf with regard to the access and use of eCHN eReferral Portal, eReferral Gateway, and the External eReferral Application, for the purpose of the submission and management of patient referrals on my behalf. I take sole responsibility for my authorized User's access and use of the eCHN Portal, eReferral Gateway, External eReferral Application. I acknowledge that I have read, understand and agree in my personal capacity to comply with the eCHN eReferral Terms and Conditions as they apply to me as an eReferral Client (as set out in the eReferral Terms and Conditions).

☐ I authorize the eCHN Helpdesk to create on my behalf the delegation between myself (health practitioner) and my administrative/support staff signed above. I understand that 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.

Name (please print)	Date
Signature ***(eSignature NOT accepted)***	College License Number

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

If you have any questions call us at:
Phone: 416-813-7998, Toll Free: 1-877-252-9900