eCHN Portal Access Application Form **CLINICIAN / PROVIDER ONLY**

Form B: New Solitary Healthcare Practitioner Client Registration

Version 5.0 (January 9, 2020)

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. ◯ 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 – 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 (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** (below).

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)
		☐ WebChart ☐ eReferral Exp. Date: ☐ Both WebChart & eReferral *(if applicable)*
		☐ WebChart ☐ eReferral Exp. Date: ☐ Both WebChart & eReferral *(if applicable)*
		☐ WebChart ☐ eReferral Exp. Date: ☐ Both WebChart & eReferral *(if applicable)*
		☐ WebChart ☐ eReferral Exp. Date: ☐ Both WebChart & eReferral *(if applicable)*

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**

eCHN Portal Access Application Form **ADMIN / SUPPORT STAFF ONLY**

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 – User/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*):	

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