OntarioMD

New EMR Adoption Program Extension 2
EMR Adopter Funding
Vendor Contract Declaration

Form Purpose: The Vendor Contract Declaration confirms that the Applicant has signed a contract with its Vendor(s) for a Funding Eligible EMR Offering and related services. This Declaration must be accompanied by the Mandatory EMR Funding Eligibility Schedule and Appendix A – Vendor and Physician Checklist. These documents must be submitted to OntarioMD within six months from the signing of the New EMR Adoption Program Extension 2 Funding Agreement.
Part of Funding Agreement: This form will be attached to and form part of the New EMR Adoption Program Extension 2 Funding Agreement.
Signing: Print out this form, complete sections A through D and have it signed by the Applicant's **Lead Physician** (Part C) and all **Participating Physicians** (Part D)
Form Submission: Submission of a completed and signed version of this form and associated documents to OntarioMD via fax (416.623.1249) or e-mail emrfunding@ontariomd.com
Questions: For more information on New EMR Adoption Program Extension 2 Funding, call the general toll free number 1-866-339-1233 or go to www.ontariomd.ca.
Next Steps*: On receipt of your completed form with the Mandatory EMR Funding Eligibility Schedule, Appendix A – Vendor and Physician Checklist and the EMR System Management Independent Undertaking, if applicable, OntarioMD will review all to determine the Applicant's eligibility for the payment of the Readiness Grant*

Part A: Group Information

Group Name *(per Ministry Funding Agmt, if applicable.)* & Contact Information	Name		Telephone #
	Address		Email
Lead Physician Name & Contact Information *(where different from above)*	Name *(first/last)*	Address	
	Telephone #	Email Address	CPSO#
OntarioMD Practice Management Consultant			

Part B: EMR Vendor & Product Information

○ ASP **OR** ○ Local EMR ○ Will join a Vendor Collaboration Network

OR ○ Have attached EMR System Management Independent Undertaking

EMR Vendor Name	
Name of Funding Eligible EMR Offering	Vendor Version #
If Oscar, please provide OSP	

Part C: Lead Physician Vendor Contract Declaration

I, the undersigned, acting as the Applicant's authorized representative and Lead Physician:

Contract Confirmation: acknowledge that the Applicant and all Participating Physicians have entered into a contractual agreement with all vendor(s) associated with the Applicant's deployment of a certified EMR and services as required under the New EMR Adopter Funding Agreement; and

Privacy Consent: understand and consent that the information on this form will be collected, used, retained and disclosed to administer the New EMR Adoption Program and not for any other purposes. Only persons and organizations authorized by OntarioMD and eHealth Ontario shall have access to and use of this information.

Lead Physician Signature

CPSO #	Signature	Signing Date

Part D: Participating Physician Declarations & Signatures

We, the undersigned, understand that I / we are participating in the New EMR Adopter Funding Program and:

Status: confirm that we are members of the Applicant Group identified in Part A of this Vendor Contract Declaration;

Payment Arrangements: agree that all payments for Participating Physicians under the New EMR Adopter Funding Agreement will be made to a single bank account designated by the Applicant in the Electronic Funds Transfer (EFT) Form;

Using EMR: confirm that I/we will be using the selected certified EMR application and version; and

Privacy Consent: understand and consent that the information on this form will be collected, used, retained and disclosed to administer the EMR Adopter Program and not for any other purposes. Only persons and organizations authorized by OntarioMD and eHealth Ontario shall have access to and use of this information.

Physician Information	Name *(first/last)*	Email Address
	Practice Location Address	CPSO#
	Signature	Signing Date
Physician Information	Name *(first/last)*	Email Address
	Practice Location Address	CPSO#
	Signature	Signing Date
Physician Information	Name *(first/last)*	Email Address
	Practice Location Address	CPSO#
	Signature	Signing Date
Physician Information	Name *(first/last)*	Email Address
	Practice Location Address	CPSO#
	Signature	Signing Date
Physician Information	Name *(first/last)*	Email Address
	Practice Location Address	CPSO#
	Signature	Signing Date
Physician Information	Name *(first/last)*	Email Address
	Practice Location Address	CPSO#
	Signature	Signing Date
Physician Information	Name *(first/last)*	Email Address
	Practice Location Address	CPSO#
	Signature	Signing Date

Part E: Cancellation of Physician Contract with the Vendor	
I, the Applicant, am terminating my contract with my EMR Vendor as the selected EMR Offering's Funding Eligibility has been suspended or withdrawn. The Vendor has not met the required: ◯ Technical Implementation Date (TID) ◯ Upgrade Date	
Lead Physician Signature	Date

Reviewed by PMC/Date	Date Approved	Funded by/Date