EMR Adoption Program
Notice of Change Form

Form Purpose: Use this form to notify OntarioMD of changes that could affect the Applicant's participation in EMR Adoption Program funding. This includes changes to the certified EMR used by the Applicant, the Applicant's contact information, participation of physicians in the group (departures, replacements and additions), restructuring of the Applicant's practice and practice closure.

Banking Changes: For changes to banking information or receipt of remittance advices, please use the Electronic Funds Transfer (EFT) Form.

Part of EMR Adoption Program Funding Agreement: This form will be attached to and form part of the EMR Adoption Program Funding Agreement.

Signing: Print this form, complete the section for the change(s) you wish to report and have the form signed by the Applicant.

Form Submission: Please mail the completed and signed original of this form to OntarioMD at:	EMR Adoption Program Funding OntarioMD Inc. 150 Bloor Street West, Suite 900 Toronto, ON M5S 3C1	**Questions:** For more information on the EMR Adoption Program or legacy funding programs, please call 1-866-339-1233 or visit www.ontariomd.ca

Next Steps: Upon receipt of the completed form, OntarioMD will review it to determine whether changes need to be made to the Applicant's program funding or participation. If a Notice of Change adds new Participating Physicians, key dates will need to be set for delivery of supporting program forms (e.g., the Vendor Contract Declaration, Mandatory EMR Funding Eligibility Schedule, Vendor and Physician Checklist (Appendix A)), Go-Live Declarations and confirmation of Implementation Acceptance Testing (IAT) Review.

Part A: Applicant Information

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

Part B: Addition / Transfer In of a Participating Physician (Use this section to report the addition or Transfer In of new Participating Physicians.)

1. Physician Name, Contact & EMR Information	Name (first/last)			CPSO #		Telephone #			
	Email			Clinic Address					
	EMR Vendor Name	EMR Specification Version #	Vendor EMR Version #	EMR Offering Type ☐ ASP OR ☐ Local EMR	If Oscar, please provide OSP	Config Type	OLIS Connection Date	HRM Connection Date	Upgrade Date

Check (✓) one of the following:

☐ Addition of a New Physician ☐ Transfer In* (Sign Declaration below) ☐ Replacement for Departing Physician: Name (first/last) of Replaced Physician _____

*Declaration (To be signed if Transfer In) I, the following, who is currently receiving funding under OntarioMD's EMR Adoption Program, hereby declare that I have departed from my group. Please transfer the funding position and all EMR funding due to the group as listed under Part A.

Signature_____ Date_____

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2. Physician Name, Contact & EMR Information	Name (first/last)			CPSO #			Telephone #		
	Email			Clinic Address					
	EMR Vendor Name	EMR Specification Version #	Vendor EMR Version #	EMR Offering Type ☐ASP OR ☐Local EMR	If Oscar, please provide OSP	Config Type	OLIS Connection Date	HRM Connection Date	Upgrade Date

Check (✓) one of the following:

☐ Addition of a New Physician ☐ Transfer In* (Sign Declaration below) ☐ Replacement for Departing Physician: Name (first/last) of Replaced Physician _____

*Declaration (To be signed if Transfer In) I, the following, who is currently receiving funding under OntarioMD's EMR Adoption Program, hereby declare that I have departed from my group. Please transfer the funding position and all EMR funding due to the group as listed under Part A.

Signature_____ Date_____

Part C: Departure / Transfer Out of a Participating Physician (Use this section to report the departure, replacement and/or Transfer Out of a Participating Physician.)

1. Departing and/or Transfer Out Physician Name & Contact Information	Name (first/last)	CPSO #	Effective Departure Date	Expected Return Date:	Temporary Leave of Absence: (*Yes/No*)

Departure Scenario:

☐ Seeking Replacement ☐ NOT Seeking Replacement ☐ Transfer Out* (complete the section below)

*Declaration (To be signed if Transfer Out) I, the following, who is currently receiving funding under OntarioMD's EMR Adoption Program, hereby declare that I have departed from my group. Please transfer the funding positon and all EMR funding due to the new group.

Signature_____ Date_____

2. Departing and/or Transfer Out Physician Name & Contact Information	Name (first/last)	CPSO #	Effective Departure Date	Expected Return Date:	Temporary Leave of Absence: (*Yes/No*)

Departure Scenario:

☐ Seeking Replacement ☐ NOT Seeking Replacement ☐ Transfer Out* (complete the section below)

*Declaration (To be signed if Transfer Out) I, the following, who is currently receiving funding under OntarioMD's EMR Adoption Program, hereby declare that I have departed from my group. Please transfer the funding positon and all EMR funding due to the new group.

Signature_____ Date_____

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Part D: Other Changes *(Use this section to report other changes that could affect the Applicant's participation in the program such as EMR locations, contact information, restructuring of the Applicant's practice, practice closure, lead physician change, etc.)*

Provide Details of Change:

Part E: Participating Physician Signatures (**For physicians in Part B**)

I/We, the undersigned, as new or replacement Participating Physician(s):

- understand I/we are applying for EMR Adoption Program funding and acknowledge that all payments will be made to the Applicant's bank account designated in the Electronic Funds Transfer Form; and
- acknowledge that I/we will be required to submit all required supporting documents (e.g., Vendor Contract Declaration and Scope of Work (SOW), Go-Live Declarations with confirmation of Implementation Acceptance Testing under the SOW and Performance Declarations) by the specified dates as is required for the administration of the EMR Adoption Program funding ; and
- **Privacy Consent:** I / We understand and consent that the information on this form will be collected, used**,** retained and disclosed to administer the EMR Adoption Program and not for any other purposes. Only persons and organizations authorized by OntarioMD shall have access to and use of this information.

1. Participating Physician Signature

Physician Name (first/last)	Signature	Signing Date

2. Participating Physician Signature

Physician Name (first/last)	Signature	Signing Date

Part F: Lead Physician Declaration

I, the undersigned, acting as the Applicant's authorized representative and Lead Physician, am notifying OntarioMD of changes in the Applicant's participation in the EMR Adoption Program and am the contact for legal notifications.

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

Lead Physician Declaration & Signature

CPSO #	Signature	Signing Date

For OntarioMD Use Only:	Check (✓) one of the following: ☐ IAT Review Required or ☐ IAT Review **Not** Required	
Reviewed by PMC/Date	Approved by/Date	Funded by/Date