# NOTICE OF CHANGE

**Who should use this Notice of Change?**

- Complete this Notice if you are the Lead Physician or the designated IT Lead of an eligible Primary Care Group and you need to report changes to physician participation in the Primary Care IT Funding Plan.

**When should this form be used?**

- Use this Notice to report changes:
  - when an existing or new group member elects to participate in the Primary Care IT Funding Plan – please note that if this Notice of Change adds new participating physicians in a new location additional supporting documents (Vendor Contract Declaration, Go-Live Declaration and Scope of Work) will also be required
  - when a participating physician elects to upgrade from the Desktop to the Comprehensive Package
  - to report changes in the number of participating physicians in your Group
  - to report a change in the Clinical Management System (CMS) product being used

While not necessarily included in this form, please ensure that you notify OntarioMD of any changes to contact information that may affect Remittance Advices.

**Where do you send your completed Notice of Change?**

- Return the signed original to your Transition Specialist by mail or courier to:

The Primary Care IT Funding Plan
c/o OntarioMD
150 Bloor St. West, Suite 900
Toronto, ON M5S 3C1

**Where do I get more information?**

- For more information on the Physician IT Program, including the Primary Care IT Funding Plan, call 1-866-744-8668 or go to the Physician IT Program site at www.ontariomd.ca.

**Privacy Statement**

The information on this form will be collected, retained and used to administer the Physician IT Program and not for any other purposes. Only persons and organizations authorized by OntarioMD shall have access to and use of this information.

# NOTICE OF CHANGE

## Part A: Group Information

| | |
|---|---|
| **Group Name** (same as Ministry Funding Agreement) | |
| **Name of Lead Physician** | |
| **Name of IT Lead** (if different than above) | |

## Part B: New Participating Physician

Complete this section if you are adding a **new** participating physician, and complete Part G Comprehensive Package (Comp); Desktop Package (Dsktp)

| | Physician Name | Address and Phone Number | Comp (Y/N) | Dsktp (Y/N) |
|---|---|---|---|---|
| 1 | | | | |
| 2 | | | | |
| 3 | | | | |

## Part C: Departure of a Participating Physician

Complete this section to report the **departure** of a participating physician

| | Physician Name | Departure Date (dd/mm/yyyy) | Replacement Being Sought (Y/N) |
|---|---|---|---|
| 1 | | | |
| 2 | | | |
| 3 | | | |

## Part D: Replacement of a Participating Physician

Complete this section if you are **replacing** a participating physician who has departed the group

| | Physician Name | Address and Phone Number | Effective Date | Comp (Y/N) |
|---|---|---|---|---|
| 1 | | | | |
| 2 | | | | |
| 3 | | | | |

## Part E: Upgrade to the Comprehensive Package

Complete this section for participating physicians who **upgrade** to the Comprehensive Package, and complete Part G

| | Physician Name | Address and Phone Number | Effective Date |
|---|---|---|---|
| 1 | | | |
| 2 | | | |
| 3 | | | |

## Part F: Change in CMS

Complete this section if you are **changing** to a different CMS or to notify us when a physician **discontinues use** of the funded CMS

| | Physician Name | Name of new approved product (if any) | Discontinued Use of CMS (Y/N) | Effective Date |
|---|---|---|---|---|
| 1 | | | | |
| 2 | | | | |
| 3 | | | | |

## Part G: Comprehensive Package Only

| | | | |
|---|---|---|---|
| **Name of approved CMS Application selected** | | **Version of approved CMS Application selected** | |
| **Name of Product Vendor** | | **Go-Live Date** | |

## Part H: Physician Signatures

Complete this section if you are a new, replacement or upgrading physician.

I/We the undersigned understand that we are applying to the Primary Care IT Funding Plan and that all payments will be made to the group.

I/We acknowledge that we are members of the Group and signatories to the group's contract with the Ministry of Health and Long-Term Care and that we have read and agreed to the Terms and Conditions outlined in the IT Appendix of the group's contract.

I/We understand that as a new, replacement, or upgrading participating physician, I am required to submit all required supporting documents referred to in the IT Appendix.

I/We understand that tools, guides, best practices, and Transition Specialists are available to the group through the Transition Support Program.

I/We understand and consent that the information on this form will be collected, retained and used to administer the Physician IT Program and not for any other purposes. Only persons and organizations authorized by OntarioMD shall have access to and use of this information.

| | Physician Name (Please Print) | Signature | Date |
|---|---|---|---|
| 1 | | | |
| 2 | | | |
| 3 | | | |
| 4 | | | |
| 5 | | | |

## Part I: Lead Physician Signature

As Lead Physician, I am notifying OntarioMD of changes in the group's participation in the Primary Care IT Funding Plan.

| Name (please print) | Signature | Date |
|---|---|---|
| | | |

**OntarioMD use only:**

| Reviewed by Specialist/Date: | Approved by/Date: | Funded by/Date: |
|---|---|---|
| | | |