



**EMR Adoption Program
New EMR Adopter Funding
Notice of Change Form**

Form Purpose: Use this form to notify OntarioMD of changes that could affect the Applicant's participation in the New EMR Adopter Funding . This includes changes in the Applicant's EMR (product and version), EMR usage, EMR locations, circuit changes, contact information, physician participation (departures, replacements and additions), Applicant restructuring and practice closure.

Banking Changes: For changes to banking information or receipt of remittance advice please use the EFT Form.

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

Signing: Print out this form, complete the section for the change(s) you wish to report and have the form signed by the Applicant's **Lead Physician** (Part H) and all **new and replacement Participating Physicians** (Part G).

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| Form Submission: Mail or courier a completed and signed original of this form to OntarioMD at the following address: New EMR Adopter Funding Ontario MD Inc. 150 Bloor Street West, Suite 900 Toronto, ON, M5S 3C1 Fax: 416 623-1249 | Questions: For more information on New EMR Adopter Funding , call the general toll free number 1-866-744-8663 or go to www.ontariomd.ca. |
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Next Steps: On receipt of your 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 and Scope of Work (SOW), Go-Live Declarations and confirmation of Implementation Acceptance Testing under the SOW and Performance Declarations).

Part A: Applicant Information

| | | | | |
|--|----------------------------|---------------|-------|--|
| Applicant Name (<i>per Ministry Funding Agmt, if applicable</i>) & Contact Information | Name | Telephone # | | |
| | Address | Email | | |
| Lead Physician Name & Contact Information (<i>where different from above</i>) | Name (<i>first/last</i>) | Address | | |
| | Telephone # | Email Address | CPSO# | |
| OntarioMD Practice Management Consultant | | | | |

Part B: Adding a Participating Physician (*Use this section to report the addition of new Participating Physicians.*)

| | | | | |
|--------------------------------------|----------------------------|---------------|----------------------|--|
| Physician Name & Contact Information | Name (<i>first/last</i>) | Telephone # | CPSO# | |
| | Address | Email Address | # of Active Patients | |
| Physician Name & Contact Information | Name (<i>first/last</i>) | Telephone # | CPSO# | |
| | Address | Email Address | # of Active Patients | |
| Physician Name & Contact Information | Name (<i>first/last</i>) | Telephone # | CPSO# | |
| | Address | Email Address | # of Active Patients | |

Part C: Departure of a Participating Physician (*use this section to report the departure of a Participating Physician.*)

| CPSO # | Name (<i>first/last</i>) | Effective Departure Date | Seeking Replacement (<i>yes/no</i>) | Funding to be Returned (<i>yes/no</i>) |
|--------|----------------------------|--------------------------|---------------------------------------|--|
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Part D: Replacement for a Participating Physician (*use this section to report the replacement for a departing Participating Physician.*)

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|--------------------------------------|----------------------------|---------------|------------|----------------------|
| Physician Name & Contact Information | Name (<i>first/last</i>) | Telephone # | CPSO# | # of Active Patients |
| | Address | Email Address | Start Date | |
| Physician Name & | Name (<i>first/last</i>) | Telephone # | CPSO# | # of Active Patients |

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|--------------------------------------|-------------------|--|---------------|----------------------|
| Contact Information | Address | | Email Address | Start Date |
| Physician Name & Contact Information | Name (first/last) | | Telephone # | CPSO# |
| | Address | | Email Address | # of Active Patients |
| | | | | Start Date |

Part E: Changes in Physician EMR Use (use this section to report when a Participating Physician discontinues use of a funded EMR.)

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|--------------------------------------|-------------------|--|----------------------|--------------------|
| Physician Name & Contact Information | Name (first/last) | | CPSO# | Telephone # |
| | Address | | # of Active Patients | Date EMR Use Ended |
| Physician Name & Contact Information | Name (first/last) | | CPSO# | Telephone # |
| | Address | | # of Active Patients | Date EMR Use Ended |

Part F: Changes in EMR & EMR Upgrades (use this section to report upgrading of or changes in the funded EMR.)

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|---------------------------------|---|-----------------------------|--------------------------|--|
| Check (√) one of the following: | <input type="checkbox"/> Change in Selected EMR | | or | <input type="checkbox"/> Upgrade of Deployed EMR |
| Vendor Name | | | Vendor EMR Version # | |
| Name of Certified EMR Product | | EMR Specification Version # | Effective Date of Change | |

Part G: Other Changes (use this section to report other changes that could affect the Applicant's participation in the program such as EMR locations, circuit changes, contact information, Applicant restructuring and practice closure)

Details of Change Here

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|----------------------------|--------------|-------------|---------------|
| Contact to Discuss Changes | Contact Name | Telephone # | Email Address |
|----------------------------|--------------|-------------|---------------|

Part H: Participating Physician Signatures (for new physicians in Part B and replacement physicians in Part D)

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

- understand I/we are applying for New EMR Adopter 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 SOW and Performance Declarations) by the specified dates as is required for the administration of the New EMR Adopter Funding ; 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 Name (first/last) | Signature | Signing Date |
|-----------------------------|-----------|--------------|
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Part I: Lead Physician Go-Live 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 New EMR Adopter Funding program; 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.

| | | |
|--|-----------|--------------|
| Lead Physician Declaration & Signature | | |
| CPSO # | Signature | Signing Date |

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| Reviewed by PMC/Date | Approved by/Date | Funded by/Date |
|----------------------|------------------|----------------|