



**EMR Adoption Program  
New Adopter EMR Funding  
Performance Declaration**

**Form Purpose:** The Declaration confirms the Applicant's listed Participating Physicians are using the selected version of the certified EMR product in their practices for the lesser of 2/3 or 600 of their rostered / active patients to manage the care of these patients.

**EMR Use Survey:** Participating Physicians must confirm they have completed the EMR Use Survey. The survey and instructions can be found at <http://www.ontariomd.ca/cmsusersurvey>.

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

**Signing:** Print out this form, complete Parts A through C and have it signed by the Applicant's **Lead Physician** (Part C).

<p><b>Form Submission:</b> Mail or courier a completed and signed original of this form to OntarioMD at the following address:</p> <p align="center">New EMR Adopter Funding OntarioMD Inc. 150 Bloor Street West, Suite 900 Toronto, ON, M5S 3C1                      Fax: 416 623-1249</p>	<p><b>Questions:</b> For more information on New EMR Adopter Funding, call the general toll free number 1-866- 744-8663 or go to <a href="http://www.ontariomd.ca">www.ontariomd.ca</a>.</p>
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**Next Steps:** On receipt of the Declaration, OntarioMD will review it and confirm completion of the Survey to determine whether Performance Grants should be paid.

**Part A: Applicant Information**

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

**Part B: Participating Physicians** (*as of the date of this Declaration*)

CPSO#	Name ( <i>first/last</i> )	# of Rostered / Active Patients		CPSO#	Name ( <i>first/last</i> )	# of Rostered / Active Patients

**Part C: Signature & Performance Declaration**

I, the undersigned, acting as the Applicant's authorized representative and Lead Physician confirm that each of the Participating Physicians listed above:

- are now eligible to receive the Performance Grant as they each are using a certified EMR for the lesser of 2/3 or 600 of their rostered/active patients, where possible, to make patient appointments, enter encounter notes for patients seen, enter problem lists for patients seen, make new prescriptions / renewals, to generate automated alerts / reminders to support care delivery and receive lab results electronically, directly into the EMR from the private labs supported by the EMR Specification, that are used by the physician; and
- have completed the **EMR User Survey**.
- **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.

<b>Lead Physician Signature</b>		
CPSO #	Signature	Signing Date

Reviewed by PMC/Date	Approved by/Date	Funded by/Date
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