



**EMR Adoption Program  
New 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 certified EMR product and related services. This Declaration must be accompanied by the planned Scope of Work (SOW) signed by the Applicant and its Vendor.

**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 sections A through E and have it signed by the Applicant's **Lead Physician** (Part D) and all **Participating Physicians** (Part E).

<p><b>Form Submission:</b> Mail or courier a completed and signed original of this form with the Scope of Work attached to OntarioMD at the following address:</p> <p style="margin-left: 40px;">New EMR Adopter Funding OntarioMD Inc. 150 Bloor Street West, Suite 900 Toronto, ON, M5S 3C1</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>
---	--

**Next Steps:** On receipt of your completed form with the SOW and the EMR System Management Independent Undertaking, if applicable, OntarioMD will review both to determine whether payment of Readiness Grants should be made.

**Part A: Applicant Information**

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

**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 Certified EMR Product Vendor Version #

**Part C: Projected Go-live Date(s) By Location(s) from the Scope of Work**

Location	Date	Location	Date

**Part D: Lead Physician Vendor Contract Declaration**

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

- **Contract Confirmation:** acknowledge that the Applicant, including 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 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 Signature**

CPSO #	Signature	Signing Date
--------	-----------	--------------

## Part E: 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 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 ( <i>first/last</i> )	Email Address
	Address	CPSO#
	Signature	Signing Date
Physician Information	Name ( <i>first/last</i> )	Email Address
	Address	CPSO#
	Signature	Signing Date
Physician Information	Name ( <i>first/last</i> )	Email Address
	Address	CPSO#
	Signature	Signing Date
Physician Information	Name ( <i>first/last</i> )	Email Address
	Address	CPSO#
	Signature	Signing Date
Physician Information	Name ( <i>first/last</i> )	Email Address
	Address	CPSO#
	Signature	Signing Date
Physician Information	Name ( <i>first/last</i> )	Email Address
	Address	CPSO#
	Signature	Signing Date
Physician Information	Name ( <i>first/last</i> )	Email Address
	Address	CPSO#
	Signature	Signing Date

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