

Date:

## Completion Instructions

- Fill out this form electronically by entering your information directly into each applicable field.
- Complete all fields as specified (indicate "N/A" if a field is not applicable).
- Once completed, save the completed CIF to your desktop and email a copy to your Ontario Health contact.
- If your organization is a Family Health Team, Family Health Group, Family Health Organization, or Family Health Network, provide the name of the organization used in the applicable funding agreement with the Ministry of Health.
- If you are a sole practitioner operating your practice as a medical professional corporation, you may choose to provide either: (i) the corporation name (in the manner set out in your Certificate of Authorization); or (ii) your own name (with your CPSO number), as the organization name when completing the CIF.
- If you are a home and community care service provider, provide the name of the organization used in the applicable funding agreement or contract with the Local Health Information Network (LHIN) or Ministry of Health under the Home Care and Community Services Act, 1994.

### 1) Name of Organization:

Organization Name (see note above re sole practice):			
Name change or restructuring in the last eight years?	Yes	No	
For name change, provide previous name:			
For organization restructuring, provide summary of structure change (e.g., merger or acquisition):			
Local Health Integration Network (LHIN):			
Is your organization a member of an Ontario Health Team? (Specify all affiliations)			

### 2) Address of Organization:

Building Address (number and street name):		Suite Number (if applicable):	
Building Name (for multi-building sites):			
City/Town:		Postal Code:	
Phone Number:		Extension:	
Email Address:			

### 3) Is the organization identified above in Section 1 a health information custodian (HIC) within the meaning of the *Personal Health Information Protection Act, 2004 (PHIPA)*?

**Note:** As defined in PHIPA, a HIC is an individual or organization who has custody or control of personal health information as a result of or in connection with performing their powers or duties in health care. A HIC operates under its own authority and controls who may access and use personal health information in its custody (organization types below). For example, an individual operating as a sole physician or sole nurse practitioner, who controls access and use of their patients' health records is a HIC; however a physician or nurse practitioner working for an organization, such as a family health team or hospital, or providing services to any organization under locum, is not a HIC, as the organization they work for controls access to and use of those patient health records.

Yes, a HIC

No, not a HIC

Indicate the applicable organization type below (select only one):

Ambulance Service	Pharmacy - Accreditation#:	Family Health Team
Aboriginal Health Access Centre	Public Hospital	Family Health Group
A centre, program or service for community health or mental health	Private Hospital	Family Health Organization
Service provider under the <i>Home Care and Community Services Act</i>	Public Health Unit	Family Health Network
Community Health Centre	Retirement Home licensed under the <i>Retirement Homes Act, 2010</i>	Midwifery Practice/Clinic
Designated Psychiatric Facility under the <i>Mental Health Act</i>	Long-Term Care Home under the <i>Long Term Care Homes Act, 2007</i>	Sole Physician or Physician Group Practice
Independent Health Facility as licensed under the <i>Independent Health Facilities Act</i>	NPAO listed Nurse Practitioner Led Clinic	Walk-in clinic
Oncology Centre	Sole Nurse Practitioners and Nurse Practitioners in a Group Practice	
Other (specify):		

**\*Note:** for regulated health professionals in private/community practice not addressed above indicate "Other" and provide the type of practice

If the organization identified in Section 1 above has more than one facility or location, or operates within or is affiliated with another organization (e.g. you operate a practice from a hospital, or you are affiliated with FHT, FHO or FHG), list all below:

Facility/location or other organization name	Address	Is this facility/location a separate legal entity?		Is this facility/location a separate health information custodian (HIC)?	
		Yes	No	Yes	No
		Yes	No	Yes	No
		Yes	No	Yes	No
		Yes	No	Yes	No
		Yes	No	Yes	No
		Yes	No	Yes	No

**Note:** If any facilities, locations or organizations listed above are separate health information custodians (HIC)s, a separate CIF and agreement may be required for each.

4) Legal status of the organization identified in Section 1 above (check all that apply):

Registered under the <i>Business Names Act</i> (Ontario)	
Partnership under the <i>Partnerships Act</i> (Ontario)	
Limited partnership under the <i>Limited Partnerships Act</i> (Ontario)	
Corporation under the <i>Business Corporations Act</i> (Ontario)	
Corporation under the <i>Corporations Act</i> (Ontario)	
Corporation under the <i>Not-for-profit Corporations Act</i> (Ontario)	
Health Professional Corporation under the <i>Business Corporations Act</i> (Ontario)	
No legal status	
Created under statute (specify e.g. <i>Public Hospitals Act</i> )	
Other (specify):	

**5) Signing Authority (person with authority to sign on behalf of the organization identified in Section 1 above):**

<b>First Name:</b>		<b>Last Name:</b>	
<b>Title:</b>			
<b>Email Address:</b>			

*If the organization identified in Section 1 above requires two Signing Authorities to bind the organization, provide the second Signing Authority's information when submitting this CIF.*

**6) Authorized Representative (contact for notice on agreement-related matters):**

<b>First Name:</b>		<b>Last Name:</b>	
<b>Title:</b>			
<b>Phone Number:</b>		<b>Ext.:</b>	<b>Fax Number:</b>
<b>Email Address:</b>			

**7) Privacy Officer or delegate (contact for notices on privacy matters):**

<b>First Name:</b>		<b>Last Name:</b>	
<b>Title:</b>			
<b>Phone Number:</b>		<b>Ext.:</b>	<b>Fax Number:</b>
<b>Email Address:</b>			
<b>Privacy Officer Address (if different from above):</b>			

**8) Security Officer or delegate (contact for notices on security matters):**

<b>First Name:</b>		<b>Last Name:</b>	
<b>Title:</b>			
<b>Phone Number:</b>		<b>Ext.:</b>	<b>Fax Number:</b>
<b>Email Address:</b>			
<b>Security Officer Address (if different from above):</b>			

**9) Local Help Desk (if applicable) (contact for notices on planned or unplanned system outages and upgrades and provides tier 1 technical support to the organization's employees)**

<b>First Name:</b>		<b>Last Name:</b>	
<b>Title:</b>			
<b>Phone Number:</b>		<b>Ext.:</b>	<b>Fax Number:</b>
<b>Email Address:</b>			

**10) Notification Contacts (contact for notices on planned or unplanned system outages and upgrades. An organization may add or change notification contacts at any time by calling 1-866-250-1554):**

<b>First Name:</b>		<b>Last Name:</b>	
<b>Title:</b>			
<b>Phone Number:</b>		<b>Ext.:</b>	<b>Fax Number:</b>
<b>Email Address:</b>			

<b>First Name:</b>		<b>Last Name:</b>	
<b>Title:</b>			
<b>Phone Number:</b>		<b>Ext.:</b>	<b>Fax Number:</b>
<b>Email Address:</b>			

**11a) Indicate below all applicable health care activities:**

<b>Health care means any observation, examination, assessment, care, service or procedure that is done for a health related purpose and:</b>	
➤ that is carried out or provided to diagnose, treat or maintain an individual’s physical or mental condition	
➤ that is carried out or provided to prevent disease or injury or to promote health	
➤ that is carried out or provided as part of palliative care	
➤ includes the compounding, dispensing or selling of a drug, a device, equipment or any other item to an individual, or for the use of an individual, pursuant to a prescription	
➤ includes a community service that is described in subsection 2 (3) of the <i>Home Care and Community Services Act, 1994</i> and provided by a service provider within the meaning of that Act; (“soins de santé”)	

**11b) If the organization identified in Section 1 does not provide health care services as defined above, list the services provided (Note: If you are not providing ‘health care’, you will not be eligible to access EHR services):**

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**12 a) Indicate the number of each types of roles/staff employed/contracted by the organization identified in Section 1 above (indicate number for all that apply) and the types of roles/staff within the organization requiring access to Ontario Health services (indicate number for all that apply):**

	<b>Employed/contracted by your organization (specify the number)</b>	<b>Requiring access to Ontario Health services (specify the number)</b>
<b>Physicians</b>		
<b>Nurses</b>		
<b>Nurse Practitioners</b>		
<b>Allied Healthcare Professionals</b>		
<b>Administrative Staff</b>		
<b>Other (specify type and numbers):</b>		

**12b) Based on the number of staff at your organization, do you now or in the future plan to sponsor additional users further to the individuals listed above?**

Yes      No

