Individual Registration and Service Enrolment

Use this form to register and/or enrol an individual for VPN – HSP service

Form Completion Instructions

1. This form must be completed for each new applicant:
   - New applicants must complete all sections in Part 1- Applicant.
   - Existing registrants must complete only the following sections in Part 1- Applicant:
     a) Section 1A- Applicant Details
     b) Section 1C- Healthcare Professional Designation: Provide Professional Designation information to Local Registration Authority if it has been changed or has not been previously provided.
     c) Section 1E- Notice of Collection
2. All fields must be completed as specified. Mandatory fields are marked with an asterisk. Indicate "N/A" if a field is not applicable.
3. The Local Registration Authority must complete Part 3 of the form.
4. The Local Registration Authority must **fax** the completed form to the eHealth Ontario Registration Authority for processing.
5. Further completion instructions are located at the end of this form.

Part 1 - Applicant

1A - Applicant Details

- *Existing Registrants – **Provide Login Name (first.last@oneid.on.ca)** and continue with sections 1A, 1C and 1E.*

Salutation * ☐ Dr. ☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms.	Legal First Name *	Preferred First Name	Middle Name(s)
Gender * ☐ Male ☐ Female	Legal Last Name *	Preferred Last Name	Date of Birth * *(yyyy-mm-dd)*

Organization Name * *(e.g., Twin Falls Health Sciences Network)*	Location Name *(e.g., ABC General Hospital)*	
Business Address * *(Number and Street)*	Suite/Unit/Floor	City/Town *

Province *	Postal Code *	Business Telephone * *(incl. Extension)*	Business Email *
ON			

1B – Documents to Support Identity - *To be completed by the **Local Registration Authority** for **new applicant**. For privacy reasons, please return the identity document(s) to the applicant and do NOT make copies. (A birth certificate and driver's licence are examples of documents that support identity. See the full list of acceptable documents in the attached instructions).*

Document 1 * *Provide a document from the primary identity documents list. (See instructions.) Recording the expiry date is mandatory for Document 1, if it has one.*

	Document Description *	Document Number *	Expiry Date *(yyyy-mm-dd)*
1			

Document 2 * Provide *a document from either the primary or secondary identity documents lists. (See instructions.) Recording the document number and expiry date is not required.*

	Document Description *
2	

1C – Healthcare Professional Designation – *To be completed by the **Local Registration Authority** for **new applicant or existing registrant.** Healthcare Professional Designations are assigned by one of Ontario's Regulated Health Profession Colleges. Professional Designations will be used to manage access if the applicant is invited to enrol in applications such as the Ontario Lab Information System and Cancer Care Ontario. (See the full list of authorized Professional Colleges in the attached instructions)*

Regulated Health Profession College *	Registration/License Number *
Regulated Health Profession College *	Registration/License Number *

1D – Service Desk Challenge Questions - *To be completed by the **new applicant** or the **Local Registration Authority**. Challenge Questions are used by the Service Desk to verify your identity. Review the Acceptable Challenge Questions from the list below. Choose two questions and enter the corresponding letters (A, B, C, etc.) with your answers in the fields below.*

A. What was your nickname as a child? B. Who was your first employer? (e.g. name of company) C. What year did you leave home? D. What was your mother's first job?	E. What is the middle name of your father? F. What is your oldest sibling's middle name? G. What school did you attend for sixth grade? H. What was the name of your first stuffed animal? I. What city or town was your mother born in?	J. What was your maternal grandfather's profession? K. Name of first pet? L. What is your paternal grandmother's maiden name? M. What was the first movie you ever saw?

Challenge Question #1 *(enter letter)**		Answer to Challenge Question #1	Challenge Question #2 *(enter letter)**		Answer to Challenge Question #2

1E – Notice of Collection – *This section to be completed by **new applicants** and **existing registrants** to gain consent for this request.*

The registration system is managed by eHealth Ontario (the "**Agency**"). The Agency's collection of information about identifiable individuals ("**personal information**") is governed by the Freedom of Information and Protection of Privacy Act, R.S.O. 1990, c. F.31 (the "Act"). Under the Act, the Agency may collect personal information whenever the collection is necessary for the proper administration of the Agency's authorized activities.

The purpose of this collection is to register persons to use the Agency's information infrastructure, to verify the identity of persons registering or registered to use the Agency's information infrastructure, and to maintain and administer the registration of such persons. The collection, use, and disclosure of personal information for these purposes is expressly authorized by s. 16, Ontario Regulation 43/02 made under the Development Corporations Act, R.S.O. 1990, c. D.10.

If you have any questions, or for further information about the collection described above, please contact the Chief Privacy Officer, Privacy and Security, at eHealth Ontario: P.O. Box 148, 777 Bay Street, Suite 701, Toronto, Ontario M5G 2C8, Tel: (416) 586-6500.

I confirm that the details above are correct. I consent to the collection, use, and disclosure of my personal information for the purposes described above and for purposes consistent with those described above.

Applicant's Signature *	Date Signed * *(yyyy-mm-dd)*

Part 2 – Sponsor Information

2A – Service Enrolment Details - *This section to be completed by the **sponsor** of the applicant or the **Local Registration Authority** on behalf of the sponsor.*

Service Enrolment *	Specify the service, application or role(s) to which applicant requires access *
☐ Hosted Service Provider – with Secure Token ☒ eHealth Ontario Portal	

If the e-Health service specified above requires a secure token for access, and the applicant has been previously provided with a token by eHealth Ontario, please provide the **token serial number**:

2B – Sponsor Details - *This section to be completed by the **sponsor** or the **Local Registration Authority** on behalf of the sponsor. Specify organization name, location name, and address only if different from the applicant. Contact information (e.g., business telephone and/or business email) must be provided.*

Salutation * ☐ Dr. ☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms.	First Name *	Legal Last Name *

Business Telephone * *(incl. Extension)*	Business Email

☐ Address Same as Applicant *(If checked, the remaining Address fields in this section are not mandatory.)*

Organization Name * *(e.g., Twin Falls Health Sciences Network)*	Location Name *(e.g., ABC General Hospital)*

Business Address * *(Number and Street)*	Suite/Unit/Floor

City/Town *	Province *	Postal Code *
	ON	

I authorize the applicant's access to the above service enrolment(s).

Sponsor's Signature *	Date Signed * *(yyyy-mm-dd)*

☐ Sponsorship Received via Other Methods *(e.g., email, memo)*. Sponsor signature is not required.	Specify Method: ☐ Email ☐ Memo ☐ Other (specify):

Part 3 – Local Registration Authority

3A – Local Registration Authority Details - *This section to be completed by the **Local Registration Authority**. Specify organization name, location name, and address only if different from the applicant. Contact information (e.g., business telephone and/or business email) must be provided.*

Salutation * ☐ Dr. ☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms.	First Name *	Legal Last Name *
Business Telephone * *(incl. Extension)*		Business Email

☐ Address Same as Applicant *(If checked, the remaining Address fields in this section are not mandatory.)*

Organization Name * *(e.g., Twin Falls Health Sciences Network)*		Location Name *(e.g., ABC General Hospital)*
Business Address * *(Number and Street)*		Suite/Unit/Floor
City/Town *	Province * **ON**	Postal Code *

I confirm that I have reviewed the applicant's identity documents and this application for registration and/or service enrolment.

Local Registration Authority's Signature *	Date Signed * *(yyyy-mm-dd)*

1. *Fax completed form to eHealth Ontario **Toll free at 1-866-831-0107***
2. *Email the registrant's name only to registration.agents@ehealthontario.on.ca. (**DO NOT** email completed form)*

***Note:** Once confirmation of user registration has been received, handle all original forms in accordance with your organizations Privacy, Security and document management policy.*

Notes

Form Completion Instructions (click on the attached and print if required)

Form Completion Instructions.pdf