Individual Registration and Service Enrollment / Account Request Form

Note: When registration is completed, handle all original forms in accordance with your organization's privacy, security and document management policy. For details on the form, review the form appendix. Queensway Carleton Hospital (QCH) manages user registration for the Shared Health Integrated Information Portal ("SHIIP"). The Freedom of Information and Protection of Privacy Act, R.S.O. 1990, c. F.31 ("FIPPA"), govern QCH's collection of information about identifiable individuals ("personal information").

The purpose of this collection is to register persons to use SHIIP, to verify the identity of persons registering or registered to use SHIIP, and to maintain and administer the registration of such persons, including communicating with such persons about SHIIP by email. Under FIPPA s38 (2), QCH may collect personal information whenever the collection is necessary for the proper administration of its lawfully authorized activities. QCH manages registration as part of the services it supplies for enabling health information custodians to use electronic means to collect, use, modify, disclose, retain, or dispose of personal health information through SHIIP.

If you have questions about the collection, use or disclosure of personal information, please contact the Privacy Officer and Freedom of Information Coordinator, 3045 Baseline Road Ottawa, Ontario, K2H 8P4, Phone: 613-721-2000 ext. 2915

* Indicates a required field

1A - Applicant Details – Reference the Form Appendix for more details.

This form is to: ◉ **Create new account** ○ **Update account information**

Legal First Name *		Legal Last Name *	
Middle Name		Year of Birth * *(yyyy)*	
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 *	Organizational Email Address *	
Business Telephone * *(incl. Ext.)*		Personal Telephone * *(For receiving login credentials)*	

1B – Healthcare Sector of Applicant - Reference the Form Appendix for more details on each field.

Sector *

- ☐ Primary care
- ☐ Hospital
- ☐ Addictions and Mental Health
- ☐ Community Support Services
- ☐ Home and Community Care
- ☐ Other _____

1C ☐ Select User's Access Group* – Select any groups relevant to the user's role. Reference the Form Appendix for a complete description of User Access Groups.

Access to PHI

- ☐ Site Privacy Officer
- ☐ Service Coordinators-Non Home Support
- ☐ Service Coordinators-Home Support
- ☐ CSS Care Planning
- ☐ AMH Case Managers
- ☐ Clinical Service Provider
- ☐ Care Coordinators
- ☐ Data Entry Support
- ☐ Clinical Decision Support
- ☐ Health Records

Access to PII (Personally Identifiable Information)

- ☐ Site LRA
- ☐ Non Clinical Decision Support
- ☐ IVC Program Manager

Supplementary Functions

- ☐ Manage the organization's practice list: activate, patient membership, roster status
- ☐ Disable resource intensive features (for hospital users)
- ☐ mHOMR score
- ☐ Hospital Surge Monitoring Dashboard
- ☐ HSMD Data Validation
- ☐ HSMD Data Validation – All Access
- ☐ Manage HSMD
- ☐ Hospital Data Validation

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1D – Attestation of Privacy Training * – Please check that you have completed privacy training within the last year . ☐ Yes

Source of privacy training * _____

Date of most recent privacy training * _____

1E – Applicant Signature

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.

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

1F – LRP/LRA Confirmation

Does this account require an expiry date? * ◯ No ◯ Yes	Please indicate date of expiry * *(yyyy-mm-dd)*
LRP/LRA * *(please print)* LRP/LRA * *(signature)*	Date Signed * *(yyyy-mm-dd)*