



**EMR Adoption Program
New EMR Adopter Funding
Electronic Funds Transfer (EFT) Form**

Form Purpose: Use this form to set up or change the Applicant's funding payment arrangements under the New EMR Adopter Funding program.

Mandatory Information: All information requested below is mandatory. The name on the voided cheque attached to this form **must match** the Applicant name.

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 F and have Part F signed by the Applicant's **Lead Physician** and such **other person(s)** required under the Applicant's banking authorizations (Part F).

<p>Form Submission: Mail or courier a completed and signed original of this form with voided cheque attached to OntarioMD at the following address: New EMR Adopter Funding Ontario MD Inc. 150 Bloor Street West, Suite 900 Toronto, ON, M5S 3C1</p>	<p>Questions: For more information on New EMR Adopter Funding, call the general toll free number 1-866-744-8663 or go to www.ontariomd.ca.</p>
Fax: 416 623-1249	

Next Steps: On receipt of your form OntarioMD will set up or change the Applicant's banking information.

Part A: Applicant Information			
Applicant Name (<i>per Ministry Funding Agmt, if applicable</i>) & Contact Information	Name		Telephone #
	Address		Email
Lead Physician Name & Contact Information (<i>where different from above</i>)	Name (<i>first/last</i>)		Address
	Telephone #	Email Address	CPSO#

Part B: Initial Set-up or Change (<i>Indicate below if this form is for the initial set-up of or change in instructions.</i>)	
<input type="checkbox"/> Initial Set-up of EFT/Remittance Advice instructions	or <input type="checkbox"/> Change in EFT/Remittance Advice instructions

Part C: Financial Institution Information	
Financial Institution Name & Address	Institution Name
	Address
	City

Part D: Bank Account Information	
Bank Transit #	Bank #
Account #	
<input type="checkbox"/> Voided cheque from the Applicant's account attached. <input type="checkbox"/> If a Group – Two different physician signatures in Part F.	

Part E: Remittance Information (<i>indicate below whether you want to receive EFT payment details</i>)	
<input type="checkbox"/> Email	Email Address
<input type="checkbox"/> Check here if no remittance advice is required.	

Part F: Signatures & Declaration (<i>Please provide the complete name of each signatory</i>)			
We, the undersigned:			
<ul style="list-style-type: none"> Bank Selection: confirm that we are members of the Applicant identified above and that the account specified above is the bank account selected by the Applicant for deposit of all New EMR Adopter Funding payments. 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. 			
CPSO#	Lead Physician Name (<i>first/last</i>)	Signature	Signing Date
CPSO#	Other Name (<i>first/last</i>)	Signature	Signing Date

For Internal Use Only					
Finance Account ID	Y				