eDOCSNL
ELECTRONIC MEDICAL RECORD

Med Access EMR User Addition and Training Application

To add a new EMR user to your clinic, please complete the steps below.

Please note:

- The clinic signing authority must approve the addition of a new user, by signing below in Step 4.
- FFS/Private Pay providers must sign and return the eDOCSNL EMR Participation Agreement before the process can begin. See Step 3 on how to obtain a copy of the agreement.

Step 1: Clinic Information

_____ _____
Clinic Legal Name Corporation Number

_____ _____
Clinic Address City/Town/Postal Code

_____ _____ _____
Clinic Phone # Clinic Email Address Clinic ID/Mnemonic

Step 2: User Information

_____ _____ _____
Last Name First Name Middle Name/Initial

_____ _____ _____
Email Address Primary Phone # Cell Phone #

- Select _____ _____
Role Specialty (if applicable) License # (if applicable)

_____
MCP Billing #

◯ FFS Family Medicine ◯ FFS Specialist ◯ NP Private ◯ NLHS Salaried Provider (View Only)

_____ _____ - Select _____ _____
EMR Start Date EMR End Date EMR eResults Effective Date for eResults

EMR Add ons: ☐ eFax ☐ eReferral ☐ Virtual Visits

CorCare Link: Y/N Register here: https://carelink.epic.nlhealthservices.ca/EpicCareLink/common/account_request_main.asp

Are you part of a Blended Capitation Group? - Select If yes, please specify group: _____

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Previous TELUS Med Access Training? - Select _____ If yes, where? _____

If no EMR training, please provide 3 dates you are available for training and identify topics you would like to cover:

_____

Will you be a regularly scheduled user at the clinic identified above? - Select _____

Or will you be covering for another EMR Licensed provider in the clinic identified above (ie: Locum)? - Select _____

Are you, or will you be working at another clinic in addition to the one listed above in Step 1? - Select _____

If yes, please specify: _____

Step 3: Provider Participation Agreement (EMR Providers only: MD, NP, RN Prescriber)

_____

Provider's email address to send the EMR Participation Agreement Package

Step 4: Authorization

I, _____, as the clinic signing authority, authorize _____

to access to personal health information of patients in the clinic named above.

_____ _____

Clinic Signing Authority Signature Date

Step 5: Submit Application

Email: info@edocsnl.ca

Fax: (709) 752-6529

***Note**: Please contact MCP if a new Provider will be using Med Access for billing.*

Personal information collected on this form is collected under the Newfoundland and Labrador Access to Information and Protection of Privacy Act and will only be used for the administration of eDOCSNL. Inquiries about the use and protection of this personal information should be directed to the ATIPPA Coordinator at NL Health Services.