Uniform Resource Identifier (URI) Request Form

This form will assist in the assignment of new URI(s) for your organization.

If you are requesting URI(s) for more than one health care organization (e.g. Hospital, Family Health Team, Independent Health Facility), please fill in one form for each requesting organization.

## Section 1: Submitter/Contact Information (Mandatory)

|  |  |
| --- | --- |
| First Name: | Enter First Name |
| Last Name: | Enter Last Name |
| Email: | Enter Email |
| Tel: | Enter Telephone |
| Organization of the submitter: | Submitter’s Organization |
| Submitter Role/Job Title: | Submitter’s Role or Title |

## Section 2: Background Information (Mandatory)

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| Project /Electronic Health Record (EHR) Asset for which the URI(s) is requested:  Example: eConsult implementation | Enter associated Project or EHR Asset |
| Reason for the request:  Example: adding new contributing source to Provincial Client Registry (PCR) | Purpose of URI Request |

## Section 3: Organization Information (Mandatory)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Name of the health care organization for which the URI(s) is requested: | | |  | | | |
| Affiliated LHIN: | | |  | | | |
| Building Address (number and street name): |  | | | Suite Number (if applicable): | |  |
| Building Name (for multi-building sites): |  | | | P.O. Box (if applicable): | |  |
| City/Town: |  | | | Postal Code: | |  |
| **Organization Type:** | | | | | | |
| Ambulance Service  Aboriginal Health Access Centre  A centre, program or service for community health or mental health  Service provider under the Home Care and Community Services Act  Community Health Centre  Designated Psychiatric Facility under the Mental Health Act  Independent Health Facility  Oncology Centre | | Pharmacy  Public Hospital  Private Hospital  Public Health Unit  Retirement Home licensed under the Retirement Homes Act, 2010  Long–Term Care Home under the Long Term Care Homes Act, 2007  Nurse Practitioner Led Clinic  Midwifery Practice/Clinic | | | Family Health Team  Family Health Group  Family Health Organization  Family Health Network  Primary Care Network  Sole Physician or Physician Group Practice  Walk-in clinic  Other: specify details | |
|  | | | | | | |
| **If there has been any change to the organization (e.g. name change, merger, split) in the last 8 years, please fill in the following information.** | | | | | | |
| Nature of the organization change: | | | New Organization Merger Split Name change Other: specify details | | | |
| Details pre-change  Example: previous legal name, previous member sites, other information | | | Details of pre-changes | | | |
| Details post-change  Example: new legal name, new member sites, other information etc.) | | | Details of the post-changes | | | |

## Section 4: URI Request Details (Mandatory)

Please check the type of URIs you would like to request (check all that apply).

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| **Request - Please provide details of the requested URI, including the represented concept and purpose of use:** |
| Details of the request |