

Generic Email Account Registration and Enrolment Request Form

MOHLTC
Ontario Public Drugs Program (OPDP)

Use this form to register and/or enrol an individual for Email (Generic Account) and ONE® Pages Service.

ON/ODP Unique Identifier:

A generic account is an anonymous email attributed to only one contact person as the custodian of the account.

(Note: Unique ID is 10 characters, 2-3 letters and 7-8 numbers)

FORM COMPLETION INSTRUCTIONS

- This form must be completed for each new applicant for email:
 - New applicants must complete Part 1 of the form.
- Part 2B – Generic Email account details must be completed.
- All fields must be completed as specified. **Mandatory fields are marked with an asterisk.** Indicate “Not Applicable” or “N/A” if a field is not applicable.
- Sign the Notice of Collection and Consent section.
- The Pharmacy must return pages 1-3 of the completed form to the OPDP Registration Unit via **fax**.
- The OPDP Registration Unit must return this form to eHealth Ontario Registration Agents via **fax**.

Part 1 – Applicant Information

1A - Applicant Details - This section to be completed by the pharmacist.

Salutation* <input type="checkbox"/> Dr. <input type="checkbox"/> Mr. <input type="checkbox"/> Miss <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	Legal First Name*	Preferred First Name	Middle Name(s)
Gender* <input type="checkbox"/> Male <input type="checkbox"/> Female	Legal Last Name*	Preferred Last Name	Date of Birth* (yyyy-mm-dd)
Organization Name* MOHLTC - OPDP	Pharmacy Name*		
Business Address* (Number and Street)		Suite/Unit/Floor	City/Town*
Province* ON	Postal Code*	Business Telephone* (incl. Extension)	Contact Business Email*

Provide Login Name if an existing registrant* (e.g., first.last@oneid.on.ca)

1B – Service Desk Challenge Questions - To be completed by the 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?	F. What is your oldest sibling's middle name?	J. What was your maternal grandfather's profession?	
B. Who was your first employer? (e.g. name of company)	G. What school did you attend for sixth grade?	K. Name of first pet?	
C. What year did you leave home?	H. What was the name of your first stuffed animal?	L. What is your paternal grandmother's maiden name?	
D. What was your mother's first job?	I. What city or town was your mother born in?	M. What was the first movie you ever saw?	
E. What is the middle name of your father?			
Challenge Question #1 (enter letter)	Answer to Challenge Question #1	Challenge Question #2 (enter letter)	Answer to Challenge Question #2

1C – Documents to Support Identity - To be completed by the Local Registration Authority.

	Document Description*	Document Number*	Expiry Date (yyyy-mm-dd)
1	Pharmacist OCP Number		N/A
2	Pharmacy Licence Number (OCP Number of Pharmacy)		N/A

1D – Notice of Collection and Consent

The registration and enrolment system for the ONE ID credential and the ONE Mail generic account sponsored by the Ministry of Health and Long-Term Care (“Ministry”) 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.

eHealth Ontario is collecting personal information about you on this form, indirectly from the Ministry’s Ontario Public Drug Programs. The purpose of the collection of personal information on this form by eHealth Ontario is to register you to use the Agency’s information infrastructure, provide a ONE ID authentication credential, enrol you into Agency sponsored services (e.g. ONE Mail) to verify your identity as a person registering or registered to use the Agency’s information infrastructure, and to maintain and administer your registration and enrolment. The collection, use, and disclosure of personal information for these purposes are authorized under 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 Vice President & Chief Privacy Officer at eHealth Ontario: P.O. Box 148, 777 Bay Street, Suite 701, Toronto, ON 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.

Applicant’s Signature*

Date Signed (“Effective Date”)* (yyyy-mm-dd)

Part 2 – Sponsorship Information (For Ministry Use Only)

2A – Service Enrolment Details - This section to be completed by the **Local Registration Authority** on behalf of the sponsorship Organization. Select the appropriate enrolment.

Service Enrolment*

Email and ONE Pages

2B – Generic Account details

Display Name*

(e.g., Help Desk. This is the Generic Account name that will be displayed in the ‘From’ field of an email, a combination of the Pharmacy Name and the City of the pharmacy)

Email prefix for Generic Email Account*

(Note: e-mail prefix for OPDP accounts is unique 10 character identifier)

ON/ODP#@one-mail.on.ca

2C – Sponsorship Organization Details

This section to be completed Local Registration Authority on behalf of the sponsorship Organization. Specify organization name, location name, and address only if different from the applicant.

Organization Name* (e.g., Twin Falls Health Sciences Network)

[MOHLTC - OPDP](#)

Location Name (e.g., ABC pharmacy)

Business Address* (Number and Street)

[Hepburn Block](#)

Suite/Unit/Floor

[9th Floor](#)

City/Town*

[Toronto](#)

Province*

[ON](#)

Postal Code*

[M7A 1R3](#)

Sponsorship Received via Other Methods (e.g., email, memo).

Specify Method:

Other (specify): [As per Alternative Registration Policy Assessment: Ontario College of Pharmacists](#)

Part 3 – Local Registration Authority Information (For Ministry Use Only)

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* <input type="checkbox"/> Dr. <input type="checkbox"/> Mr. <input type="checkbox"/> Miss <input type="checkbox"/> Mrs. <input type="checkbox"/> 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) MOHLTC	Location Name (e.g., ABC General Hospital) Ontario Public Drugs Program (Registration Unit)	
Business Address* (Number and Street) 1055 Princess Street	Suite/Unit/Floor Suite 302	
City/Town* Kingston	Province* ON	Postal Code* K7L 5T3

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 generic account name 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.