Mississauga Halton Central Intake Program

Halton Healthcare

☐ MULTI- PHYSICIAN PRACTICE REGISTRATION

Provider Organization Information

Individual forms **MUST** be submitted for **ALL** healthcare professionals that wish to register for eReferral. ***MANDATORY INFORMATION***

***Legal Name of Organization**	Legal Name:	
***User Account Information** (Healthcare Professional)	NAME:	
	DESIGNATION:	BILLING #:
	ADDRESS:	
	PRACTICE NAME:	
	PHONE:	
	FAX:	
	*EMAIL:	
Designated Contact Person (Office Manager, Referral Clerk, Healthcare Professional etc.)	NAME:	
	ADDRESS:	
	PHONE:	
	FAX:	
	EMAIL:	
Privacy Officer of Organization	NAME:	
	ROLE:	
	PHONE:	
	EMAIL:	
****Signing Authority(ies)** (Individual has legal authority to bind the party entering into the Agreement)	**NAME (1):**	**NAME (2):**
	TITLE:	TITLE:
	PHONE:	PHONE:
	*EMAIL:	E-MAIL:
Delegate Information: (WOULD HAVE ACCESS TO SUBMIT REFERRALS ON YOUR BEHALF)	NAME:	
	EMAIL:	
	PHONE:	

Please fill out and email the form back to
MHCentralIntake@haltonhealthcare.com