Kensington Health
The Eye Bank of Canada

Ontario Health
Trillium Gift of Life Network

Clear Form

Surgeon Portal User Access Request Form

Please Note: An email address is required for each user in the system and for password management.

SURGEON PRACTICE INFORMATION			
Surgeon First Name:		**Surgeon Last Name:**	
CPSO#		**Phone:**	
Email:			

SURGEON LOCATION INFORMATION	
Surgery Location #1	
Address:	
Surgery Location #2	
Address:	
Surgery Location #3	
Address:	

PORTAL ADMINISTRATOR INFORMATION

Identify **one (1)** individual who will act as the **Portal Administrator (or Super-User)** for your practice. This person will be responsible for adding or removing users and will be responsible for training new users within your practice on an ongoing basis. Portal Administrators will have access to view, add, modify, and delete requests for tissue. *It is recommended that the portal administrator selected is the individual who is currently responsible for ordering corneal tissue.*

Only one administrator is assigned per surgeon practice. By submitting this form, the individual identified below will be assigned as the most current Portal Administrator and will replace any previous administrators for your practice.

First Name:		**Last Name:**	
Title:		**Phone**	
Email:			
If this admin orders tissue for other surgeons' list other surgeons' names here:			

General Privacy and Security Information

The Eye Bank of Canada (EBC) requests that you to adopt best practices to protect personal health information. Accordingly, the following precautions should be taken when accessing and using the Eye Bank of Canada Surgeon Portal:

- Do not share your surgeon portal user IDs or passwords with anyone, including other staff within your organization.
- Access to records should be limited to only those records required for the purposes of entering/updating tissue request information or how it relates to your role and responsibilities.
- Comply with your organization's privacy and information system policies relating to the access to or use of the Portal;
- Advise your organization's privacy office immediately upon learning that any patient health data has been used, accessed, disclosed, or disposed of contrary to your organization's privacy policy.

Surgeon Authorization:

I, _____ (please print your given name and surname) approve the access to the Surgeon Portal requested for the above-named employees. If this employee leaves my practice, I will notify my practice's Portal Administrator so that system access will be removed.

_____ _____

Signature Date