Job Title	
Street Address	
Suite/Unit/Floor	
City/Town	
Postal Code (e.g. K1A0B1)	
Business Telephone (e.g. 1234567890)	
Business Telephone Extension	
Business Fax (e.g. 1234567890)	
Business Email Address	

Part 5: Identity Provider (iDP)
The Participant will obtain iDP services from:

Hamilton Health Sciences (default unless otherwise specified) ONE® ID (with ONE ID credentials provided by eHealth Ontario) Our organization as an eHealth Ontario Federated Identity Provider

Agreement:
I am the individual identified in Part 3 above and warrant that I have authority to bind the Participant organization identified in Part 1 above (the "Participant") with respect to the site(s) and program(s) identified in Part 2 above. By signing this form, I agree, on behalf of Participant, to the ClinicalConnect Terms and Conditions set out at http://info.clinicalconnect.ca/CCC/agreements. I also confirm that HHS may take day-to-day instruction from the Privacy Contact identified in Part 4 above, as may be changed from time to time upon written notice to HHS.

Where an individual is agreeing to this Participation Agreement on behalf of a physician practice (whether as a Sole Practitioner, partnership or corporation) then such Participant acknowledges that he or she will need to individually act as the Participant's ClinicalConnect Local Registration Authority and that the associated tasks may not be delegated.

Legal Signing Authority Full Name	
Date	