Ontario eConsult Program

Follow-up request form

eConsult BASE™
Ontario eConsult Centre of Excellence

Legal First Name: _____ **Legal Last Name:** _____

Profession: _____

Specialty/Sub-specialties (if applicable) _____

CPSO or CNO Registration #: _____ **OHIP Billing #** _____

Organization Legal Name: _____

Organization Address: _____

City: _____ **Postal Code:** _____

Phone (incl. extension): _____ **Fax:** _____

ONE ID Account: _____

Email: _____

Once complete, please forward to:

Ontario eConsult Centre of Excellence

eConsultCOE@toh.ca

Disclaimer: By providing this information you confirm that the Ontario eConsult Centre of Excellence may collect, use and disclose this information in order to follow-up with you and/or support you with signing up for the Ontario eConsult Program. This may include disclosing this information to other relevant parties in order to provide you with the requested services.