OPOR Provider Portal New Setup or Change User Access Request form

Required signatures: Authorized signatory (pg 4 only), User (pg 3 & 4)

USER INFORMATION: **To ensure the accuracy and integrity of the form submission process, all fields are mandatory and must be completed by the user, including the manager's details (e.g. license number, name, etc.), prior to signing and saving the form. Once the user has signed and saved the form, the manager will no longer have the ability to edit or add any information. The manager's role will then be limited to reviewing the form and adding their signature. The user is required to sign and submit the Provider Portal Access Request Form and the Provider Portal User Access Agreement in PDF format and email them to opor.providerportal@nshealth.ca**

◯ New / Reactivation OPOR Provider Portal Access Request	◯ Change OPOR Provider Portal Access Request
◯ Deactivation OPOR Provider Portal Access Request	Enter Existing OPOR Provider Portal User ID (If Applicable):
* **NOTE:** This option is for direct access to OPOR Provider Portal.	

NOTE: Applicant's First Name, Middle Name, and Last Name are **MANDATORY.** If a Middle Name does not exist, please write N/A
Enter Name exactly as appears on professional license (if applicable)

Last Name:		First Name:	
Middle Name:		Preferred or Nickname:	
Position Title:		Professional License # (if applicable):	
Reason For Request:			
Health Care Organization Name:			

Have you had a OPOR Provider Portal account previously? ☐ Yes ☐ No

Are you a NS Licensed Provider (Physician, Nurse Practitioner, Pharmacist)? ☐ Yes ☐ No
Note: All other clinicians/admins require a signature from a licensed manager or supervisor

Digital Identity Information

Email Address: **NOTE**: OPOR Provider Portal allows registration with your own email address using Microsoft Azure B2B. We do not require you to create an email address at NSH to use this service - one less password to remember.

All Applicants must complete this section

Note: The supervisor/manager is the person who has the legal authority to hold a healthcare professional/staff person working at the site accountable in the event of a privacy breach.

Healthcare Organization or Employer

Organization Name:	
Street Address:	
City:	
Province:	Select your Province
Postal Code:	
Phone Number:	
Supervisor/Manager Name:	
Contact Email address:	

Note: If you work for more than 1 HCO, please fill the details below and get the form signed by your concerned HCO's

Healthcare Organization or Employer	
Organization Name:	
Street Address:	
City:	
Province:	Select your Province
Postal Code:	
Phone Number:	
Supervisor/Manager Name:	
Contact Email address:	

Healthcare Organization or Employer	
Organization Name:	
Street Address:	
City:	
Province:	Select your Province
Postal Code:	
Phone Number:	
Supervisor/Manager Name:	
Contact Email address:	

Healthcare Organization or Employer	
Organization Name:	
Street Address:	
City:	
Province:	Select your Province
Postal Code:	
Phone Number:	
Supervisor/Manager Name:	
Contact Email address:	

Duration of Access			
Access start date:	(DD/MM/YYYY)	**Access end date(Optional):**	(DD/MM/YYYY)

Agreements and Signature

Request OPOR Provider Portal Access

B2B End User Agreement	(Click to open the link in new tab)	**Your Initials here:**
NSH Acceptable Use of Information Technology	(Click to open the link in new tab)	**Your Initials here:**
NSH Pledge of Confidentiality	(Click to open the link in new tab)	**Your Initials here:**
NSH Administrative Policy and Procedure	(Click to open the link in new tab)	**Your Initials here:**
DHW Privacy Statement	(Click to open the link in new tab)	**Your Initials here:**

To demonstrate their agreement, the parties have signed below:

I HEREBY CERTIFY that the information provided in this form is complete, true and correct to the best of my knowledge.

Name:		**Title:**	
Date:	(DD/MM/YYYY)	**Signature:**	(Sign here)

(**Note:** This can be filled out by the Supervisor/Manager for clinicians, or the manager/employer for admins. They can also provide some legal details about the PHCO. Supervisor/Manager must review "**OPOR Provider Portal User Agreement**", "**B2B End User Agreement**", "**NSH Acceptable use of Information Technology**", "**Pledge of Confidentiality**" and "**Administrative Policy and Procedure**" before signing.)

Supervisor/Manager Signature

Supervisor/Manager Name:			
Organization Legal Name:			
Type:	Select organization type		
Title:		**Professional License #:**	
Date:	(DD/MM/YYYY)	**Signature:**	(Sign here)

Supervisor/Manager Name:			
Organization Legal Name:			
Type:	Select organization type		
Title:		**Professional License #:**	
Date:	(DD/MM/YYYY)	**Signature:**	(Sign here)

Supervisor/Manager Name:			
Organization Legal Name:			
Type:	Select organization type		
Title:		**Professional License #:**	
Date:	(DD/MM/YYYY)	**Signature:**	(Sign here)

Supervisor/Manager Name:			
Organization Legal Name:			
Type:	Select organization type		
Title:		**Professional License #:**	
Date:	(DD/MM/YYYY)	**Signature:**	(Sign here)

Note: If you work for more than 1 HCO, please get the form signed by your appropriate Sponsors.