Schedule A

North York
Family Health Team

Contract Between North York Family Health Team (NYFHT) and NYFHT Physicians

Please note that you are responsible for completing this Application honestly and candidly. All questions must be answered. Incomplete Applications will be returned to the Applicant. ***Capitalized terms used in this Application are defined in NYFHT's Physician Contract Policy and Procedures.***

PART ONE – BASIC INFORMATION

Name: (Print in block letters -- SURNAME, FIRST NAME, MIDDLE INITIAL)

Current Home Mailing Address:

Street and Number: _____ Apt. No.: _____

City: _____ Postal Code: _____

Province: _____ Telephone Number: ( ) _____

Home E-mail: _____ Home Fax: ( ) _____

Office Address:

Street and Number: _____ Suite Number: _____

City: _____ Postal Code: _____

Province: _____ Telephone Number: ( ) _____

Fax No: ( ) _____ E-Mail: _____

Preferred Address: Home ☐ Office ☐

Name of My Family Health Organization:

PART TWO – PRIVILEGES TO PRACTICE MEDICINE AT NORTH YORK GENERAL HOSPITAL

By submitting this Application, I confirm that I currently have privileges to practice medicine at NYGH. I further confirm that I am applying for reappointment to NYGH's Medical Staff.

I acknowledge and understand that obtaining and maintaining clinical privileges at NYGH is a precondition to this Contract and to my eligibility to receive NYFHT Services.

PART THREE – PRIVACY STATEMENT AND PHIPA AUTHORIZATION OF NYFHT AND NYFHT STAFF

PRIVACY STATEMENT

NYFHT is committed to receiving and treating personal information in confidence. The information in this Contract is collected and used by and on behalf of NYFHT for the purposes of evaluating the Applicant's eligibility to become a member of NYFHT's Physicians.

PHIPA AUTHORIZATION OF NYFHT STAFF

In submitting this Application, I confirm that I am the Health Information Custodian of the EMR Records relating to my patients. I further confirm that I am in compliance with my obligations as a health information custodian, as provided by the Personal Health Information Protection Act ("PHIPA"), and that I have taken and will take all necessary and appropriate steps to safeguard the privacy and security of all records of personal health information for which I am responsible. I acknowledge, understand, and agree that I shall not share or disclose, or permit the sharing or disclosing of, any such records with any third parties who are not within the circle of care of the patient or as otherwise authorized under PHIPA. If my Application for Contract is accepted by NYFHT:

(a) I agree to indemnify NYFHT, its Staff, agents, directors, and officers from all costs, damages, fines, penalties or other liabilities arising from a breach of my obligations under PHIPA or the confirmations provided in this Contract except where such breach is caused directly by the NYFHT; and
(b) NYFHT agrees to indemnify me from all costs, damages, fines, penalties or other liabilities arising from a breach of NYFHT and/or NYFHT Staff obligations under PHIPA.

Accordingly, I hereby agree that NYFHT and NYFHT Staff may access, collect, use, and/or disclose EMR Records for the following authorized purposes:

(a) to fulfill their clinical and professional obligations to shared patients;
(b) to fulfill their privacy obligations;
(c) to fulfill their administrative functions;
(d) to defend themselves in regulatory and/or other legal or administrative proceedings; and

PART FOUR – NYFHT TERMS OF USE

I understand and agree that the provision of NYFHT Services is at all times subject to availability of resources and to the following terms and conditions:

(a) NYFHT Staff Services are assigned/scheduled by NYFHT only during the hours of NYFHT's hours of operation or as may be agreed upon between NYFHT and the Physician office(s) where NYFHT Staff may be assigned;
(b) NYFHT Staff report to NYFHT's Executive Director. Issues or concerns relating to NYFHT Staff shall be communicated by NYFHT Physicians to NYFHT's Executive Director, or delegate, for management response;
(c) NYFHT Staff are able to provide Services only to patients of NYFHT's Physicians (with the exception of certain programs and Services), and to support NYFHT's own operations and programs;
(d) all personal property provided by NYFHT under this Agreement, including supplies, equipment, computers, are the sole property of NYFHT and no right, title or interest in any NYFHT-owned property is granted to NYFHT's Physicians, except for the right to use such property as reasonably expected in the course of providing health care Services; and
(e) I acknowledge and understand my responsibilities to:

    (i) comply at all times with NYFHT requirements, policies and procedures including medical directives as they may be amended from time to time;
    (ii) collaborate in hiring, integrating, evaluating and/or terminating NYFHT Staff, as may be requested by NYFHT;
    (iii) secure or arrange for, and maintain, adequate professional liability insurance;
    (iv) secure or arrange for, and maintain, adequate tenant insurance in the minimum amount as provided by NYFHT's Physician Contract Policy and Procedures;
    (v) ensure that premises in which NYFHT Staff provide NYFHT Services are, in NYFHT's reasonable view, safe and appropriate for NYFHT Staff i.e. compliance with Occupational Health and Safety Act; and
    (vi) ensure that my patients have access to NYFHT Services, including the Services of the inter-disciplinary health providers.

PART FIVE – DECLARATION

In completing and submitting this Application, I hereby apply for contract to NYFHT's Physicians.

I acknowledge and understand that I will not be eligible to receive NYFHT Services prior to my receiving official notification that NYFHT's Board of Directors has approved my Application.

If this Application is approved by NYFHT, I hereby undertake and agree to:

(a) govern myself in accordance with NYFHT's by-laws, policies, procedures; and
(b) comply with such terms, conditions, or requirements as are set by NYFHT's Management or Board policy, and in particular, with the terms of NYFHT's Physician Contract Policy and Procedures, a copy of which is appended hereto as Schedule A.

I confirm that I have been provided with and have reviewed a copy of NYFHT's by-laws.

_____	_____
(Signature of Witness)	(Signature of Applicant)
_____	_____
(Date)	(Date)
_____	_____
(Name of Witness, please print)	(Name of Applicant, please print)

This Application is approved by:

Medical Director: _____ **Date:** _____

Executive Director: _____ **Date:** _____

Chair, Board of Directors: _____ **Date:** _____

Attachment – Schedule A – NYFHT Physician Contract Policy and Procedures

Please return via email to: daddeo@nyfht.com
Or Fax: 416-623-7425