

Physician EMR Acceptance

According to your contract with your PITO-Qualified EMR vendor:

“Upon completion of the implementation of the EMR Solution by the Service Provider, the Service Provider will obtain Acceptance from the Eligible Physician(s), which Acceptance the Eligible Physicians will not unreasonably withhold.”

Acceptance is defined in your contract as:

“...the acceptance in writing by the Eligible Physician that the EMR Solution is available for use in a clinical setting in accordance with the terms of the Service Provider-Physician Agreement.”

Physician Acceptance is collected to ensure that the product and related services have been delivered as specified by your contract with your EMR vendor and the requirements referenced by that contract, and confirm that PITO should proceed to issue reimbursement to the physician for eligible implementation costs. If you have any questions concerning Acceptance that your vendor cannot address, please contact your PITO Local Relationship Manager for further information.

Upon Acceptance, the Vendor will provide you with an invoice. You should obtain and complete the “PITO Reimbursement Form” (available at www.pito.bc.ca/Documents under “Key Forms”) based on the information in the vendor invoice and receipts for other eligible expenses such as hardware.

The following should be submitted to PITO to initiate reimbursement (which should occur before your vendor fees are due provided that you submit the following right away):

1. This Physician Acceptance form
2. Vendor invoice and any other eligible expense receipts
3. PITO Reimbursement Form

A sample checklist for Acceptance is provided in this document.

Physician Acceptance Quick Reference Guide

The following is provided as a sample list of the types of requirements that are stipulated by the vendor contracts. Your contract may have additional and/or some different items.

- All functionality required by the PITO requirements has been delivered and is functional
- All templates required by the PITO requirements have been delivered and are functional
- Testing of all required interfaces is complete (ex. Excelleris, MSP billing)
- Interfaced data has been tested and is displaying correctly (e.g. lab results)
- Business Continuity Copy is configured and available
- Data conversion has been tested for data quality, if applicable
- Reference databases (Physician Database, Medications, etc.) are installed and configured
- Billing codes have been configured correctly
- All user accounts and roles-based access has been set up correctly
- Training is scheduled or has been completed as specified
- Other special requirements outlined in your vendor contract have been met (*e.g. custom interfaces, templates, etc.*):
 -
 -
 -
 -
 -
 -
 -
 -
 -

Physician EMR Acceptance

Clinic Name: _____

Clinic Contact: _____

Is the EMR Solution *“available for use in a clinical setting in accordance with the terms of [your EMR Vendor]-Physician Agreement”*?

Y N

If **no**, what conditions must be met by your vendor prior to providing Acceptance?

-
-

Please fax or email a copy of this list to your vendor to indicate conditions that must be resolved prior to Acceptance and skip the next section until they are resolved.

Physician Acceptance¹ Sign-Off *(each physician must indicate Acceptance)*

If **yes**, do any issues remain that are currently being addressed by your vendor?
(i.e. items that are required according to your contract but are not preventing your implementation and use of the EMR at this time)

-
-

Signature: _____

Date: _____
month/day/year

Name: Dr. _____

¹ *“...the acceptance in writing by the Eligible Physician that the EMR Solution is available for use in a clinical setting in accordance with the terms of the Service Provider-Physician Agreement.”*

Additional Acceptance Signatures *(use if a group practice)*

Signature: _____

Date: _____
month/day/year

Name: Dr. _____

Signature: _____

Date: _____
month/day/year

Name: Dr. _____

Signature: _____

Date: _____
month/day/year

Name: Dr. _____

Signature: _____

Date: _____
month/day/year

Name: Dr. _____

Signature: _____

Date: _____
month/day/year

Name: Dr. _____

Signature: _____

Date: _____
month/day/year

Name: Dr. _____

Signature: _____

Date: _____
month/day/year

Name: Dr. _____

Signature: _____

Date: _____
month/day/year

Name: Dr. _____