



FOR OFFICE USE ONLY	
APPROVED BY	DATE
Chapter Rep (please initial)	
BOD Rep (please initial)	

HEALTHCARE MEMBER APPLICATION FORM

DISCLAIMER: Please do not submit any identifying personal or health information.

INSTRUCTION: please complete all 6 sections before submitting. If you have any difficulty with the application form, please contact us – see last page for contact.

1. THIS APPLICATION IS FOR:

1.1 Application Date:

Applicant Type:

If you chose:

A) Main Office for a Collaborative*, check this box if the address is also a Service Location** to be included on the interactive map

B) Service Location**, please provide the name of the collaborative* you belong to so that we may verify their membership status (i.e. Calgary Foothills PCN)

C) Regulated Health Care Professional, please identify the governing college of which you are a member in good standing:

* A **Collaborative Primary Care Model** is a network or association that represents a team of healthcare professionals working together in a dedicated practice environment that includes 2 or more service locations. i.e. PCN's in Alberta, Alberta Health Services, Family Health Teams in Ontario

A **Service Location is a site that carries out the services on behalf of the collaborative primary care model. Examples: medical clinic, doctors' office, specialty department.

1.2 If you are the Main Office for a Collaborative Primary Care Model, how many locations do you have?

1.3 Total number of Physicians and Nurse Practitioners within your Clinic, Collaborative Primary Care Model or Service Location:

1.4 Total number of allied health professionals who may also be providing prescriptions to patients (if applicable):

Please list the types of allied health professionals in the box below
(i.e. registered pharmacists, registered nurses, mental health practitioners etc) (max 90 words):

1.5 Please select the EMR you use (select all that apply):

We do not use EMR

Accuro

AVA

HealthQuest

OSCAR

Telus MedAccess

Telus PS Suite

Telus Wolf

Not Listed (please specify):

Continue to Section 2

2. APPLICANT DETAILS

Company Name <i>(will appear on legal documents and map where applicable) :</i>	
Address1	
Address2	
City	
Province	
Postal Code	
Public* Phone Number	
Public* Email <i>(optional but recommended)</i>	
URL for Website or Social Media <i>(optional but recommended)</i>	

**Will appear on website profile if applicable*

3. CONTACT

First and Last Name	
Phone**	
Cell (optional)**	
Email**	

***Will not be published – for RxTGA contact purposes only*

4. DESCRIPTION & GOALS

What is your clinic/collaborative's interest in being a member of Prescription to Get Active? (Please cover these items: Why is physical activity important for your patients? What are you trying to achieve by prescribing/referring your patient physical activity?) *(max. 450 words)*

5. PATIENT DEMOGRAPHIC REQUIREMENTS

5.1	Do you have adult or senior patients who do not meet the recommended 150 minutes of moderate to vigorous physical activity per week?	YES	NO
5.2	Do you have children or youth patients who do not meet the recommended 60 minutes of moderate to vigorous physical activity per day?	YES	NO
5.3	Do you have patients who can participate in physical activity without clinical supervision and/or medical clearance?	YES	NO

6. EVALUATION REQUIREMENTS

6.1.	Your organization is willing to pre-screen for physical activity readiness using an evidence-based screening tool/methodology as a first step in ensuring a safe and enjoyable physical activity experience and providing or supporting care for patients who meet the target patient population of the RxTGA initiative? Target patient populations are: - Adults who get less than 150 minutes of moderate to vigorous physical activity per week - Children and youth who get less than 60 minutes, on average, per day of moderate to vigorous physical activity - Can engage in physical activity without clinical supervision and/or medical clearance - Low risk (medically stable) and free of unstable chronic disease	YES	NO
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7. SUBMIT FORM

7.1 Using **SAVE AS**, follow the format below to name your file so we can easily identify your application:

e.g. **XYZFamilyHealthClinic-HealthcareApplication.pdf**

7.2 Email the completed application to:

administration@prescriptiontogetactive.com

NEXT STEPS

1. Your application will be reviewed for approval by the applicable Chapter and the Board of Directors
2. Upon approved, a Membership Agreement will be generated and sent to the contact noted above in Section 3 for signature and return.

Should you have any questions, please contact us at

info@prescriptiontogetactive.com or call 1-866-212-7552