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: click to choose best match from this list

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)*

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

**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***Will not be published – for RxTGA contact purposes only*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? *(max. 200 words)*

Continue to section 5

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. HEALTHCARE ORGANIZATION EVALUATION REQUIREMENTS

6.1. Your organization will commit to the mandatory quarterly reporting requirements by tracking the total number of RxTGA prescriptions written? ◯ YES ◯ NO

6.2. Reporting contact: *check BOX if same as in #3 above* ☐

OR

Name:

Email:

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