



e†

Specialist Intake Form

First Name: _____

Last Name: _____

Specialty/Sub-specialties: _____

CPSO # _____

OHIP Billing #: _____

Account type: ☐ Associated with organization ☐ Solo Account

Organization (if applicable): _____

Address: _____

City: _____

Phone (incl. extension): _____

Postal Code: _____

ONE ID Account: _____

Email: _____

Delegate Name (if applicable): _____

Delegate email (if applicable): _____

*Solo accounts are tied to the individual, and can be used with different organizations. Accounts associated with an organization can only be used with that organization.

Once complete, please forward to:

The SEAMO Digital Health Team

seamo.digitalhealth@queensu.ca

Disclaimer: By providing this information you confirm that O-° U \ may collect, use and disclose follow-up with you and/or support you with signing up for † . This may information to other relevant parties in order to provide you with the requested services.