**EMR REQUIREMENTS ATTESTATION FORM**

The responses in the EMR Requirements Attestation Formshould be based on the **current** functionality or capability of the EMR offering that the vendor is proposing, as can be substantiated by references from its existing client base.

The EMR offering **MUST** meet **ALL MANDATORY** requirements.

**SECTION 1: FOUNDATIONAL REQUIREMENTS**

**EMR Data Migration Specification**

Does the EMR offering meet **ALL** the **Mandatory Requirements** listed in the **EMR Data Migration Specification** posted on the OntarioMD website under **Current EMR Specifications**

 [ ]  Yes [ ]  No

**EMR Core Data Set Specification**

Does the EMR offering meet **ALL** the **Mandatory Requirements** listed in the **EMR Core Data Set Specification** posted on the OntarioMD website under **Current EMR Specifications**

 [ ]  Yes [ ]  No

**EMR Hosting Specification**

Does the EMR offering meet **ALL** the **Mandatory** requirements listed in the **EMR Hosting Specification** posted on the OntarioMD website under **Current EMR Specifications**

 [ ]  Yes [ ]  No [ ]  N/A

[ ] [ ] [ ] [ ] [ ]

**SECTION 2: FUNCTIONAL REQUIREMENTS**

**Primary Care EMR Baseline Specification**

Does the EMR offering meet **ALL** the **Mandatory Requirements** listed in the **Primary Care EMR Baseline Requirements Specification** posted on the OntarioMD website under **Current EMR Specifications**

 [ ]  Yes [ ]  No

List the **Optiona**l requirements that the EMR offering meets in the table below. If the EMR offering meets **ALL** the **Optional** requirements, write **ALL** in the table.

|  |  |  |  |
| --- | --- | --- | --- |
| # | OMD # | REQUIREMENT | VENDOR COMMENTS |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**EMR Chronic Disease Management (CDM) Specification**

Does the EMR offering meet **ALL** **Mandatory Requirements** listed in the **EMR Chronic Disease Management Specification** posted on the OntarioMD website under **Current EMR Specifications**

 [ ]  Yes [ ]  No

List the **Optiona**l requirements that the EMR offering meets in the table below. If the EMR offering meets **ALL** the **Optional** requirements, write **ALL** in the table.

|  |  |  |  |
| --- | --- | --- | --- |
| # | OMD # | REQUIREMENT | VENDOR COMMENTS |
|  |  |  |  |
|  |  |  |  |

**SECTION 3: VENDOR DECLARATION**

By signing below, EMR vendor acknowledges that it understands the Application process for EMR Certification and confirms that the information in this EMR Requirements Attestation Form is true, accurate and complete.

|  |  |
| --- | --- |
| **Signature:** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*I have authority to bind the Vendor* |
| **Name:** | *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* |
| **Title:** | *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* |
| **Date:** | *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Month Day, Year* |