

Request to Update OGPMSS Account Profile Form

Tel: (416) 327-0837 / Fax: (416) 327-0818

This form is intended for **Toronto** Regulated Health Professionals/Healthcare providers with an **existing** account to inform the Ontario Government Pharmaceutical and Medical Supply Services (OGPMSS) of changes to their account record.

Note: For a change of premise ownership, please complete a New Registration Application Form. If you have any questions about completion of this form, contact OGPMSS at 416-327-0837.

Please complete all sections on **BOTH** pages and Fax them to OGMPSS at **416-327-0818**.

The information on this form is collected, used and disclosed under the authority of the Health Protection and Promotion Act and in accordance with the Municipal Freedom of Information and Protection of Privacy Act.

OGPMSS ACCOUNT INFORMATION CURRENTLY ON FILE:

OGPMSS Client Number

Facility Operating Name *(The name used in the day-to-day operations of the healthcare facility)*

Legal Name of Practice/Premise

Unit Number

Street Number

Street Name

City/Town

Postal Code

SPECIFY CHANGE TO ACCOUNT PROFILE (Select ALL That Apply)

- ☐ New Regulated Health Professional/Healthcare Provider joining this Practice/Premise

- ☐ Replaced our vaccine refrigerator
- ☐ Added an additional vaccine refrigerator
- ☐ Moved the existing vaccine refrigerator to another area within our facility
- ☐ New Contact Information

Contact Name
Phone/Fax Number

Email

- ☐ Practice/Premise Name Change *(Please attach Business Name Registration Form provided by the ministry)*

New Legal Name

- ☐ Our Practice/Premise has moved to a new location

New Address

Unit Number

Street Number

Street Name

City/Town

Postal Code

- ☐ Our Practice/Premise is permanently closing

Date of Closure

Complete, sign and submit BOTH pages

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ACCOUNTABILITY STATEMENT

PLEASE NOTE:

While administrative staff are permitted to fill out these forms, the accountability statement is to be signed by a licensed physician or the authorized health professional responsible for the clinic/group.

I verify on behalf of the Practice/Premise that all information provided is accurate. I understand that changes to our address, acquisition, replacement, or relocation of a vaccine refrigerator must be reported immediately to Toronto Public Health and the Ontario Government Pharmaceutical and Medical Supply Services (OGPMSS) and will **require a cold chain inspection and record refrigerator temperatures logs for a period of one week showing that temperatures of between +2.0°C and +8.0°C are being maintained, prior to continued storage of publicly funded vaccines.** The Practice/Premise will comply with all required steps ensuing from the changes to ensure that publicly funded vaccines in the facility’s custody are safely stored and handled during the transition. Furthermore, for Practice/Premise closures, all due diligence will be taken to mitigate and minimize the wastage of publicly funded vaccines by maintaining no more than what is required to provide patient care until the date of Practice/Premise closure.

Print Name: _____

Signature: _____

Date: _____

Please fax BOTH pages to OGPMSS at 416-327-0818 and allow 2 -3 business days for processing.