Ontario

**Ministry of Health**

Assistive Devices Program

# Vendor Registration Application

## Instructions

Applicants must complete the Business and Location General Information section for each business location that is open to the public and for which registration with the ADP is being requested. Applicants are encouraged to read the Ministry's Policies and Procedures Manual for the Assistive Devices Program (ADP) and Device specific Policy and Administration Manuals prior to completing this Application, all of which are available at https://www.ontario.ca/document/assistive-devices-program-health-care-professionals

**Please note**: The submission of a vendor application does **not** imply approval for registration with the ADP. Registration as a vendor with the ADP is at the Ministry's discretion. The submission of vendor application materials is solely intended to allow the Ministry to review and assess applicants for registration as vendors with the ADP.

Listing of documents required to prepare a complete application package.

☐ 1) Vendor Registration – Business and Location General Information

☐ 2) Vendor Registration – Information Specific to Device Category
**Note:** confirm that you have completed the applicable form for the specific device category.

☐ 3) Vendor Registration – Confirmation of Payment Instruction document
**Note:** Voided cheque with correct business name must be submitted with the form.

☐ 4) Business Ownership Information/Documents, including Confirmation of business registration from the Canada Revenue Agency
See Part 2, Guide to Vendor Registration Requirements.

☐ 5) Government-Issued Photo Identification for all Owners/Board of Directors (copy must be certified by a notary or lawyer)
See Part 2, Guide to Vendor Registration Requirements.

☐ 6) Level 2 criminal record and judicial matters check for all Owners/Board of Directors
See Part 2, Guide to Vendor Registration Requirements.

☐ 7) Certificate of Insurance
See Part 4, Guide to Vendor Registration Requirements for details of insurance requirements.

☐ 8) Copy of lease agreement if located in a hospital
See Part 3, Guide to Vendor Registration Requirements.

☐ 9) Manufacturer/distributor agreements or letters
See Part 6, Guide to Vendor Registration Requirements to determine if applicable.

☐ 10) Completed and signed Questionnaire and Attestation for Applicants Seeking Registration as Vendors of Home Oxygen Therapy.

☐ 11) Joint Venture Agreement, if applicable, for Applicants Seeking Registration as Vendors of Home Oxygen Therapy (see definition in Home Oxygen Therapy Policy and Administration Manual).

Completed vendor applications may be submitted via email to adpvendors@ontario.ca. Documents which are unreadable will not be reviewed and must be resent.

Fields marked with an asterisk (*) are mandatory.

## Business and Location General Information

### Applicant Information

Legal Name of the Business

Registered Operating Name of the Business

Criminal Record and Judicial Matters Check #

Person (Name) submitted

| Last Name | First Name |
|---|---|
| | |

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Type of Business ◯Sole Proprietor ◯Partnership ◯Corporation

**Business Address**

| Unit Number | Street Number | Street Name | PO Box |
|---|---|---|---|
| | | | |

| City/Town | Province<br>Ontario | Postal Code |
|---|---|---|
| | | |

| Telephone Number | Fax Number | Business Email Address * |
|---|---|---|
| | | |

## Registration Requirements

Is this business location in Ontario and open to the public?

◯Yes ◯No

Is this business operating out of a permanent location that has the applicable municipal zoning?

◯Yes ◯No

What geographic area will be served by this business location?

In what languages are your staff able to provide services?

☐English ☐French ☐Other

Specify

Does this business location have the required insurance policy? (See the Guide to Vendor Registration Requirements, Part 4, for details.)

◯Yes ◯No

Has the owner of this business or any of its principals participated in the ADP now or in the past?

◯Yes ◯No

Name

**Address**

| Unit Number | Street Number | Street Name | PO Box |
|---|---|---|---|
| | | | |

| City/Town | Province<br>Ontario | Postal Code |
|---|---|---|
| | | |

Role with ADP

Are there any charges or convictions in respect of any offence that relate to conduct that are relevant to the applicant's participation in the ADP?

◯Yes ◯No

Specify

Is your business location compliant with the *Accessibility for Ontarians with Disabilities Act (AODA), 2005*, including any applicable regulations thereunder?

◯Yes ◯No For regulations, visit

Does your business premises provide accessibility to individuals with physical disabilities, such as entrance, restroom and assessment/fitting rooms?

◯Yes ◯No ◯N/A

Provide an explanation

If your business is incorporated, is it duly organized, registered and validly existing under the laws of Canada or Ontario and has it not been dissolved?

◯Yes ◯No ◯Not incorporated

Does your business hold all necessary permits, licenses, consents and authority to perform its obligations as a registered Vendor with the Assistive Devices Program?

◯Yes ◯No

Do all professional personnel providing services on behalf of your business have the requisite level of experience and expertise and the professional designations and credentials required to carry out their respective responsibilities in providing such services in a competent manner in accordance with all professional standards? See the Guide to Vendor Registration Requirements, Part 7, for details.

◯Yes ◯No

Is your business in compliance with all applicable federal, provincial and municipal laws, rules, orders, regulations, by-laws and policies?

◯Yes ◯No

I confirm that I have read, and I understand, and I am prepared to abide by the terms of the Policies and Procedures Manual for the Assistive Devices Program and the Device specific Policy and Administration Manuals and am prepared to abide by the policies and procedures, including the Conflict of Interest Policy.

◯Yes ◯No

I confirm that, on an annual basis, I will review the Policies and Procedures Manual for the Assistive Devices Program and the Device specific Policy and Administration Manuals, including the Conflict of Interest Policy, to ensure that I am abiding by the terms at all times.

◯Yes ◯No

## Official Signing Officer Authorization

The Ministry's collection of any personal information as part of this form is necessary for the proper administration of the Assistive Devices Program, which is authorized under the *Ministry of Health and Long-Term Care Act*, R.S.O. 1990, c. M.26, paragraph 4 of s. 6(1). Any personal information collected by the Ministry will be used in order to determine eligibility for registered vendor status under the Assistive Devices Program.

For further details concerning the Ministry's collection and use of this information, please contact the Registration Unit, Assistive Devices Program, 5700 Yonge Street, 7th floor, Toronto ON M2M 4K5. Telephone Number 416-327-8804; Toll free 1-800-268-6021; Email: adp@ontario.ca

I agree to the release of contact information for this vendor location to the public.

I have provided true and complete information in, or in relation to, this application to be eligible to participate in the Assistive Devices Program. I understand that the Ministry may reject an application that contains false or incomplete information and terminate any Agreement made with an Applicant who provided false or incomplete information.

I certify that all the answers and information provided to the Ministry as part of this Application are, to the best of my knowledge, true and accurate at the time of this Application and undertake to advise the Ministry forthwith of any changes that I become aware of. I understand that this information is subject to audit.

I understand that the Applicant is responsible for following the policies of the Assistive Devices Program and that the consequences of failing to comply with those policies could be serious and could result in corrective action against the Applicant by the Ministry or other legal action.

Official Signing Officer (the individual who has the legal authority to bind the Vendor)

Print Last Name | Print First Name

Position

Email Address *

| Signature | Date (yyyy/mm/dd) |
|---|---|
| | |

**Contact Information (Individual from the vendor who deals with ADP on an ongoing basis)**

| Last Name of Contact Person | First Name of Contact Person |
|---|---|
| | |

| Position |
|---|
| |

| Telephone Number | Fax Number | Business Email Address * |
|---|---|---|
| | | |

## Financial Institution Information

I/We authorize my/our payments be forwarded by deposit directly into the following account:
(Please attach a blank voided cheque)

| Branch Number | Institution Number | Account Number |
|---|---|---|
| | | |

* from the MICR encoding on the cheque

Name of Financial Institution

**Address**

| Unit Number | Street Number | Street Name | PO Box |
|---|---|---|---|
| | | | |

| City/Town | Province | Postal Code |
|---|---|---|
| | | |

# Void Cheque

## **Signature** (Official Signing Officer)

I/We confirm that the above information is correct.

| Name | Authorized Signature | Date (yyyy/mm/dd) |
|---|---|---|
| | | |
| Name | Authorized Signature | Date (yyyy/mm/dd) |
| | | |

## Vendor Information

| Vendor Name | Vendor Number |
|---|---|
| | |

**Address**

| Unit Number | Street Number | Street Name | PO Box |
|---|---|---|---|
| | | | |

| City/Town | Province | Postal Code |
|---|---|---|
| | | |

## Devices

**Information Specific to Categories of Devices**
The applicant must complete a separate entry for each category of devices for which they are seeking registration.

**Categories of Devices**
Select all of the categories of devices for which the applicant is requesting registration with the ADP as a Vendor.

- ☐ Bone Anchored Hearing Aid Replacement Sound Processors (BAHA)
- ☐ Cochlear Implant Replacement Speech Processors
- ☐ Communication Aids
- ☐ Hearing Aids
- ☐ Home Oxygen Therapy
- ☐ Insulin Pumps and Supplies
- ☐ Limb Prostheses
- ☐ Maxillofacial Extraoral Prostheses
- ☐ Maxillofacial Intraoral Prostheses
- ☐ Mobility Devices: Ambulation Aids
- ☐ Mobility Devices: Manual Wheelchairs
- ☐ Mobility Devices: Positioning Systems for Wheelchairs
- ☐ Mobility Devices: Power Wheelchairs, including Scooters
- ☐ Ocular Prostheses
- ☐ Orthotic Devices
- ☐ Pressure Modification Devices
- ☐ Respiratory Equipment and Supplies
- ☐ Teletypewriters for the Deaf or Speech Impaired (TTYs)
- ☐ Visual Aids

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Ministry of Health

Assistive Devices Program

# Vendor Registration Application

**Bone Anchored Hearing Aid Replacement Sound Processors (BAHA)**

Is the applicant also the manufacturer/distributor of one or more ADP listed device(s) that the Vendor will be offering for sale/dispensing?

◯Yes ◯No

Is the applicant directly or indirectly owned or otherwise controlled by the manufacturer/distributor of the ADP listed device(s)?

◯Yes ◯No

Does the applicant provide instruction to clients on the use of the device?

◯Yes ◯No

Describe the process for ensuring that the client understands how to use the device

Does the applicant offer a follow-up service program to the client?

◯Yes ◯No

Describe the service

Provide an explanation

Does the applicant honour manufacturer warranties for the type(s) of ADP listed device(s) that will be offered for sale/dispensed?

◯Yes ◯No

Provide an explanation

Is the applicant's repair service located on the applicant's premises?

◯Yes ◯No

**Provide Location**

Company Name

| Unit Number | Street Number | Street Name | PO Box |
|---|---|---|---|
| | | | |

| City/Town | Province/State | Postal/Zip Code |
|---|---|---|
| | | |

What is the applicant's policy on devices returned to the applicant by clients?

◯Accept returns within the warranty period ◯Will not accept returns ◯Other

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Provide an explanation of the vendor's policy on returns

## Employee Qualifications - Bone Anchored Hearing Aid Replacement Sound Processors

Applicants must have staff trained in the use and repair of specialized bone anchored hearing aid replacement sound processors. See the Guide to Vendor Registration Requirements, Part 7, for details. Complete this section for each staff member with applicable experience in the Bone Anchored Hearing Aid Replacement Sound Processor category who is employed by the applicant. Each employee to whom this applies is required to sign this section of the form.

**Employee Information**

| Last Name | First Name |
|---|---|
| | |

| Position | Length of employment with current employer |
|---|---|
| | |

Describe the employee's training and experience with clients and with bone anchored hearing aid replacement sound processors. Attach applicable documents to provide proof of course completion and/or qualifications.

**Employee Authorization**

The Ministry's collection of any personal information as part of this form is necessary for the proper administration of the Assistive Devices Program, which is authorized under the *Ministry of Health and Long-Term Care Act*, R.S.O. 1990, c. M.26, paragraph 4 of s. 6(1). Any personal information collected by the Ministry will be used in order to determine eligibility for registered vendor status under the Assistive Devices Program.

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I certify that all the answers and information provided to the Ministry as part of this Application are, to the best of my knowledge, true and accurate at the time of this Application and undertake to advise the Ministry forthwith of any changes that I become aware of. I understand that this information is subject to audit.

| Employee Signature | Date (yyyy/mm/dd) |
|---|---|
| | |

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Ontario

Ministry of Health

Assistive Devices Program

# Vendor Registration Application

**Cochlear Implant Replacement Speech Processors**

Is the applicant also the manufacturer/distributor of one or more ADP listed device(s) that the Vendor will be offering for sale/dispensing?

◯Yes ◯No

Is the applicant directly or indirectly owned or otherwise controlled by the manufacturer/distributor of the ADP listed device(s)?

◯Yes ◯No

Does the applicant provide instruction to clients on the use of the device?

◯Yes ◯No

Describe the process for ensuring that the client understands how to use the device

Does the applicant offer a follow-up service program to the client?

◯Yes ◯No

Describe the service

Provide an explanation

Does the applicant honour manufacturer warranties for the type(s) of ADP listed device(s) that will be offered for sale/dispensed?

◯Yes ◯No

Provide an explanation

Is the applicant's repair service located on the applicant's premises?

◯Yes ◯No

**Provide Location**

Company Name

| Unit Number | Street Number | Street Name | PO Box |
|---|---|---|---|
| | | | |

| City/Town | Province/State | Postal/Zip Code |
|---|---|---|
| | | |

What is the applicant's policy on devices returned to the applicant by clients?

◯Accept returns within the warranty period ◯Will not accept returns ◯Other

Provide an explanation of the vendor's policy on returns

## Employee Qualifications - Cochlear Implant Replacement Speech Processors

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Applicants must have staff trained in the use and repair of specialized cochlear implant replacement speech processors. See the Guide to Vendor Registration Requirements, Part 7, for details. Complete this section for each staff member with applicable experience in the Cochlear Implant Replacement Speech Processor category who is employed by the applicant. Each employee to whom this applies is required to sign this section of the form.

**Employee Information**

| Last Name | First Name |
|---|---|
| | |

| Position | Length of employment with current employer |
|---|---|
| | |

Describe the employee's training and experience with clients and with cochlear implant replacement speech processors. Attach applicable documents to provide proof of course completion and/or qualifications.

**Employee Authorization**

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| Employee Signature | Date (yyyy/mm/dd) |
|---|---|
| | |

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Ministry of Health

Assistive Devices Program

# Vendor Registration Application

## Communication Aids

Provide examples of the ADP listed devices that the applicant plans to sell or dispense under the Communication Aids category. Include the make and model for each example. Refer to the Communication Aids Product Manual.

List two (2) manufacturer lines of ADP listed devices that the applicant intends to offer for sale/dispense. Attach the manufacturer/distributor letters confirming that the applicant is an authorized dealer. See the Guide to Vendor Registration Requirements, Part 6, for details.

| Manufacturer Name | Make | Model |
|---|---|---|
| | | |
| Manufacturer Name | Make | Model |
| | | |

Is the applicant also the manufacturer/distributor of one or more ADP listed device(s) that the Vendor will be offering for sale/dispensing?

◯Yes ◯No

Is the applicant directly or indirectly owned or otherwise controlled by the manufacturer/distributor of the ADP listed device(s)?

◯Yes ◯No

Does the applicant provide instruction to clients on the use of the device?

◯Yes ◯No

Describe the process for ensuring that the client understands how to use the device

Does the applicant offer a follow-up service program to the client?

◯Yes ◯No

Describe the service

Provide an explanation

Does the applicant honour manufacturer warranties for the type(s) of ADP listed device(s) that will be offered for sale/dispensed?

◯Yes ◯No

Provide an explanation

Is the applicant's repair service located on the applicant's premises?

◯Yes ◯No

**Provide Location**

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Company Name

| Unit Number | Street Number | Street Name | PO Box |
|---|---|---|---|
| | | | |

| City/Town | Province/State | Postal/Zip Code |
|---|---|---|
| | | |

What is the applicant's policy on devices returned to the applicant by clients?

◯Accept returns within the warranty period ◯Will not accept returns ◯Other

Provide an explanation of the vendor's policy on returns

## Employee Qualifications - Communication Aids

Applicants must have staff trained in the use and repair of specialized communication aids. See the Guide to Vendor Registration Requirements, Part 7, for details. Complete this section for each staff member with applicable experience in the Communication Aids category who is employed by the applicant. Each employee to whom this applies is required to sign this section of the form.

**Employee Information**

| Last Name | First Name |
|---|---|
| | |

| Position | Length of employment with current employer |
|---|---|
| | |

Describe the employee's training and experience with clients and with communication aids. Attach applicable documents to provide proof of course completion and/or qualifications.

**Employee Authorization**

The Ministry's collection of any personal information as part of this form is necessary for the proper administration of the Assistive Devices Program, which is authorized under the *Ministry of Health and Long-Term Care Act*, R.S.O. 1990, c. M.26, paragraph 4 of s. 6(1). Any personal information collected by the Ministry will be used in order to determine eligibility for registered vendor status under the Assistive Devices Program.

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I certify that all the answers and information provided to the Ministry as part of this Application are, to the best of my knowledge, true and accurate at the time of this Application and undertake to advise the Ministry forthwith of any changes that I become aware of. I understand that this information is subject to audit.

| Employee Signature | Date (yyyy/mm/dd) |
|---|---|
| | |

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Ministry of Health

Assistive Devices Program

# Vendor Registration Application

## Hearing Aids

List four (4) manufacturer lines of ADP listed devices that the applicant intends to offer for sale/dispense. Attach the manufacturer/distributor letters confirming that the applicant is an authorized dealer. See the Guide to Vendor Registration Requirements, Part 6, for details.

Manufacturer Name

Manufacturer Name

Manufacturer Name

Manufacturer Name

Is the applicant also the manufacturer/distributor of one or more ADP listed device(s) that the Vendor will be offering for sale/dispensing?

◯Yes ◯No

Is the applicant directly or indirectly owned or otherwise controlled by the manufacturer/distributor of the ADP listed device(s)?

◯Yes ◯No

Does the applicant provide instruction to clients on the use of the device?

◯Yes ◯No

Describe the process for ensuring that the client understands how to use the device

Does the applicant offer a follow-up service program to the client?

◯Yes ◯No

Describe the service

Provide an explanation

Does the applicant honour manufacturer warranties for the type(s) of ADP listed device(s) that will be offered for sale/dispensed?

◯Yes ◯No

Provide an explanation

Is the applicant's repair service located on the applicant's premises?

◯Yes ◯No

**Provide Location**

Company Name

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| Unit Number | Street Number | Street Name | PO Box |
|---|---|---|---|
| | | | |

| City/Town | Province/State | Postal/Zip Code |
|---|---|---|
| | | |

What is the applicant's policy on devices returned to the applicant by clients?

◯Accept returns within the minimum 30 day trial period ◯Accept returns within the warranty period ◯Will not accept returns ◯Other

Provide an explanation of the vendor's policy on returns

Does the applicant have the required equipment used by authorizers for testing hearing, as specified in the Hearing Devices Policy and Administration Manual?

◯Yes ◯No

Does the applicant have the minimum required equipment used to clean, service and test hearing aids and earmolds, as specified in the Hearing Devices Policy and Administration Manual?

◯Yes ◯No

## Employee Qualifications - Hearing Aids Authorizer

An applicant may have on staff an authorizer (audiologist and/or hearing instrument specialist). The applicant must ensure that these individuals have the required qualifications. See the Guide to Vendor Registration Requirements, Part 7, for details. Applicants who have on staff ADP Registered Authorizers must provide their name(s) and ADP registration number(s).

**Authorizers**

☐Not applicable

| Name | ADP Authorizer Number |
|---|---|
| | |

## Employee Qualifications - Hearing Aids Dispensers

Applicants must have on staff a Dispenser for hearing aids and FM systems. Complete this section for each staff member with applicable experience in the Hearing Aids category who is employed by the applicant. See the Guide to Vendor Registration Requirements, Part 7, for details. Each employee to whom this applies is required to sign this section of the form.

**Employee Information**

| Last Name | First Name |
|---|---|
| | |

| Position | Length of employment with current employer |
|---|---|
| | |

Describe the employee’s training and experience with clients and with hearing aids and FM systems. Attach applicable documents to provide proof of course completion and/or qualifications.

## Employee Authorization

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I certify that all the answers and information provided to the Ministry as part of this Application are, to the best of my knowledge, true and accurate at the time of this Application and undertake to advise the Ministry forthwith of any changes that I become aware of. I understand that this information is subject to audit.

| Employee Signature | Date (yyyy/mm/dd) |
| --- | --- |
| | |

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Ontario

**Ministry of Health**

Assistive Devices Program

# Vendor Registration Application

**Questionnaire and Attestation for Applicants Seeking Registration as Vendors of Home Oxygen Therapy**

1. Provide all of the manufacturer/distributor for each type of Oxygen Delivery Systems that the applicant intends to carry for oxygen therapy in the home. Attach the applicable manufacturer/distributor (minimum of 2) letters confirming that the applicant is an authorized dealer/distributor. See the Guide to Vendor Registration Requirements, Part 6, for details.

Manufacturer/Distributor Name

Manufacturer/Distributor Name

Manufacturer/Distributor Name

Manufacturer/Distributor Name

2. Does the applicant maintain contracts with medical gas suppliers for the provision of oxygen?

◯Yes ◯No

Comment/Specify

3. Is the applicant also the manufacturer/distributor of one or more ADP listed device(s), found in the Home Oxygen Product Manual, that the applicant will be dispensing, if approved as a vendor?

◯Yes ◯No

4. Is the applicant directly or indirectly owned or otherwise controlled by a manufacturer/distributor of an ADP listed device(s), found in the Home Oxygen Product Manual?

◯Yes ◯No

5. Is the applicant's repair service located on the applicant's premises?

◯Yes ◯No

6. Does the applicant have a client safety and education policy?

◯Yes ◯No

7. Does the applicant have an infection prevention and control policy?

◯Yes ◯No

8. Does the applicant have a record-keeping policy?

◯Yes ◯No

9. Does the applicant have a staff training and education policy?

◯Yes ◯No

10. Do all the applicant's employees who would provide services to ADP clients in their homes (if the applicant is registered as a vendor) have a current Vulnerable Sector Screening?

◯Yes ◯No

## Employee Qualifications

Under the Home Oxygen Therapy category, the applicant must have employees who:

- are trained in the delivery and use of home oxygen equipment; and
- are able to provide education to ADP client(s) and/or their caregivers about how to safely and properly use home oxygen equipment.

At least one of the applicant's employees must be a Regulated Health Professional, as defined in the Home Oxygen Therapy Policy and Administration Manual.

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## Employee Information

| Last Name | First Name |
|---|---|
| Position | Length of employment with current employer |

Describe the employee's membership in a regulatory health profession college and their training and experience with Home Oxygen Therapy. Attach applicable documents to provide proof of college membership, course completion and/or qualifications.

## Employee Authorization

The Ministry's collection of any personal information as part of this form is necessary for the proper administration of the Assistive Devices Program, which is authorized under the *Ministry of Health and Long-Term Care Act*, R.S.O. 1990, c. M.26, paragraph 4 of s. 6(1). Any personal information collected by the Ministry will be used in order to determine eligibility for registered vendor status under the Assistive Devices Program.

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I certify that all the answers and information provided to the Ministry as part of this Application are, to the best of my knowledge, true and accurate at the time of this Application and undertake to advise the Ministry forthwith of any changes that I become aware of. I understand that this information is subject to audit.

| Employee Signature | Date (yyyy/mm/dd) |
|---|---|

11. Is the applicant part of a Joint Venture as defined in the Home Oxygen Therapy Policy and Administration Manual?

◯Yes ◯No

If "Yes", please provide a copy of the Joint Venture agreement and answer question 12.

If "No", please proceed to question 13.

12. If the answer to question 11 is "Yes", does the applicant intend to have an established transparent process that provides an ADP client and/or their caregiver with a list of ADP-registered vendors of home oxygen therapy located in the ADP client's community, along with each vendor's contact information, ensuring the ADP client has full discretion to select a vendor of their choice, even if it does not involve the applicant or the applicant's joint venture?

◯Yes ◯No

13. Has the applicant entered into a Preferred Vendor Agreement as defined in the Home Oxygen Therapy Policy and Administration Manual?

◯Yes ◯No

If "Yes", please answer question 14.

14. If the answer to question 13 is "Yes", does the applicant have an established transparent process that provides the ADP client and/or their caregiver with a list of ADP-registered vendors of home oxygen therapy located in the ADP client's community, along with each vendor's contact information, ensuring the ADP client has full discretion to select a Vendor of their choice, even if it is not the applicant or one of its preferred vendors?

◯Yes ◯No

The application will be considered invalid unless it includes the attestation below signed by the applicant's official signing officer.This attestation is a mandatory requirement to ensure the applicant's authenticity and accountability.

## Attestation for the applicant seeking Registration with ADP for Home Oxygen Therapy category

Please read the statements below and acknowledge your agreement with them by signing in the space provided at the bottom of the Attestation. Capitalized terms used, but not defined, in the Attestation have the meanings set out in the Policies and Procedures Manual for the Assistive Devices Program and the Home Oxygen Therapy Policy and Administration Manual, as applicable.

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I have read and understand the Policies and Procedures Manual for the Assistive Devices Program and the Home Oxygen Therapy Policy and Administration Manual and my organization's roles and responsibilities as a Vendor of Home Oxygen Therapy in Ontario if my application is accepted, including, but not limited, to making sure my organization, and my organization's employees, agents and subcontractors (as applicable), will do the following:

- provide a Client under the Assistive Devices Program with an Oxygen Delivery System(s) that meets the Clients' medical needs, including:
  - correcting or minimizing the Client's Hypoxemia;
  - allowing the Client to participate in the activities of daily living; and
  - providing a backup system in the event that the Client experiences a power failure or the equipment malfunctions;
- have employees on staff who:
  - are knowledgeable in Home Oxygen Therapy and Oxygen Delivery Systems;
  - can teach the Client and/or the caregiver the operation, care and safe handling of the Oxygen Delivery Systems; and
  - Have read and understand the **Policies and Procedures Manual for the Assistive Devices Program** and the **Home Oxygen Therapy Policy and Administration Manual**, including any updates to these Manuals that the ADP may issue;
- have on staff one or more Regulated Health Professionals;
- have one or more Regulated Health Professionals available during normal business hours to visit a Client in the Client's home if the Client, the Prescriber, or another of my employees has determined that a follow up visit, or assessment is required;
- ensure that all employees have received the appropriate training in the operation and safe handling of Oxygen Delivery Systems;
- have the inventory of Oxygen Delivery Systems to carry out the roles and responsibilities of a Vendor for Home Oxygen Therapy;
- provide 24-hour emergency service to Clients in relation to Home Oxygen Therapy;
- return telephone calls from Clients within one (1) hour;
- have an employee attend the Client's home within three (3) hours if the problem cannot be solved over the telephone, unless the Client freely states that attendance is not necessary;
- provide a basic Oxygen Delivery System for the Client to use;
- deliver, set up and pick up the Oxygen Delivery System at a Client's home;
- inspect the Client's home to determine whether it is safe for the use of the Home Oxygen Therapy;
- notify the Prescriber of Home Oxygen Therapy for a particular Client if any clinically significant changes occur in the Client's respiratory status;
- conduct regular, documented maintenance and repair of the Oxygen Delivery System as per the manufacturer's specifications and replace defective units at no additional cost to the Clients;
- provide key performance indicator metrics as set out by the ADP in the **Home Oxygen Therapy Policy and Administration Manual** to improve the program and services provided to the Clients;
- review the **Policies and Procedures Manual for the Assistive Devices Program** and the **Home Oxygen Therapy Policy and Administration Manual** regularly to keep up to date with policies and any changes made by the Ministry; and
- comply with the roles and responsibilities set out in section 115 of the **Home Oxygen Therapy Policy and Administration Manual**, as may be updated from time to time.

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I understand that if my organization or my organization's employees, agents, or subcontractors do not adhere to the **Policies and Procedures Manual for the Assistive Devices Program**, the **Home Oxygen Therapy Policy and Administration Manual**, a Vendor Agreement entered into between my organization and the Ministry or any other requirements of the ADP in relation to supplying Home Oxygen Therapy, this could result in corrective action against my organization by the Ministry, including my organization's termination as a Vendor of Home Oxygen Therapy under the ADP or other corrective actions as described in the Vendor Agreement.

By signing this Attestation, I confirm that I understand the statements set out in it, agree to them.

| Name | Title |
|---|---|
| Signature | Date (yyyy/mm/dd) |

I have authority to bind the organization.

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Ministry of Health

Assistive Devices Program

# Vendor Registration Application

**Insulin Pumps and Supplies**

Is the applicant also the manufacturer/distributor of one or more ADP listed device(s) that the Vendor will be offering for sale/dispensing?

◯Yes ◯No

Is the applicant directly or indirectly owned or otherwise controlled by the manufacturer/distributor of the ADP listed device(s)?

◯Yes ◯No

Does the applicant provide instruction to clients on the use of the device?

◯Yes ◯No

Describe the process for ensuring that the client understands how to use the device

Does the applicant offer a follow-up service program to the client?

◯Yes ◯No

Describe the service

Provide an explanation

Does the applicant honour manufacturer warranties for the type(s) of ADP listed device(s) that will be offered for sale/dispensed?

◯Yes ◯No

Provide an explanation

Is the applicant's repair service located on the applicant's premises?

◯Yes ◯No

**Provide Location**

Company Name

| Unit Number | Street Number | Street Name | PO Box |
|---|---|---|---|
| | | | |

| City/Town | Province/State | Postal/Zip Code |
|---|---|---|
| | | |

What is the applicant's policy on devices returned to the applicant by clients?

◯Accept returns within the warranty period ◯Will not accept returns ◯Other

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Provide an explanation of the vendor's policy on returns

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Assistive Devices Program

# Vendor Registration Application

## Limb Prostheses

Select the type(s) of limb prostheses for which the applicant is applying for vendor status.

☐Conventional Limb Prostheses

☐Externally Powered Upper Limb Prostheses (EPULP)

List two (2) manufacturer lines of the components that the applicant intends to offer for sale/dispense. Attach the manufacturer/distributor letters confirming that the applicant is an authorized dealer. See the Guide to Vendor Registration Requirements, Part 6, for details.

Manufacturer Name

Manufacturer Name

Is the applicant also the manufacturer/distributor of one or more of the component(s) that the Vendor will be offering for sale/dispensing?

◯Yes ◯No

Is the applicant directly or indirectly owned or otherwise controlled by the manufacturer/distributor of the component(s)?

◯Yes ◯No

Does the applicant provide instruction to clients on the use of the device?

◯Yes ◯No

Describe the process for ensuring that the client understands how to use the device

Does the applicant offer a follow-up service program to the client?

◯Yes ◯No

Describe the service

Provide an explanation

Does the applicant honour manufacturer warranties for the component(s) that will be offered for sale/dispensed?

◯Yes ◯No

Provide an explanation

Is the applicant's repair service located on the applicant's premises?

◯Yes ◯No

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**Provide Location**

Company Name

| Unit Number | Street Number | Street Name | PO Box |
|---|---|---|---|
| | | | |

| City/Town | Province/State | Postal/Zip Code |
|---|---|---|
| | | |

What is the applicant's policy on devices returned to the applicant by clients?

◯Accept returns within the warranty period ◯Will not accept returns ◯Other

Provide an explanation of the vendor's policy on returns

## Authorizer Information

Under the Limb Prostheses category, the applicant must employ a certified prosthetist who is certified by the Canadian Board for Certification of Prosthetists and Orthotists (CBCPO). See the Guide to Vendor Registration Requirements, Part 7, for details.

Provide the name(s) and ADP registration number(s) of all ADP registered certified prosthetists on staff. Select the type(s) of limb prostheses for which each person is registered

| Last Name | First Name |
|---|---|
| | |

| ADP Authorizer Number | Limb Prostheses Type(s) |
|---|---|
| | ☐Conventional Limb Prostheses ☐EPULP |

## Clinic/Team Membership

Is the applicant an active member of one or more Conventional Limb Prosthesis team(s)?

◯Yes ◯No ◯N/A

Clinic Name

Clinic Number

Is the applicant an active member of one or more Externally Powered Upper Limb Prosthesis team(s)?

◯Yes ◯No ◯N/A

Clinic Name

Clinic Number

## Location Details

In order to be registered with ADP, the applicant's prosthetic location must have transfer bars in the washrooms, parallel bars and a full length mirror in the fitting areas, private assessment and fitting areas and separate assessment, fabrication, fitting and training areas.

◯Yes, all of these requirements are present.

◯No, these requirements are not present.

Provide an explanation

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Ministry of Health

Assistive Devices Program

# Vendor Registration Application

## Maxillofacial Extraoral Prostheses

Provide examples of the ADP listed devices that the applicant plans to sell or dispense under the Maxillofacial Extraoral Prostheses category.

Does the applicant provide instruction to clients on the use of the device?

◯Yes ◯No

Describe the process for ensuring that the client understands how to use the device

Does the applicant offer a follow-up service program to the client?

◯Yes ◯No

Describe the service

Provide an explanation

Is the applicant's repair service located on the applicant's premises?

◯Yes ◯No

**Provide Location**

Company Name

| Unit Number | Street Number | Street Name | PO Box |
|---|---|---|---|
| | | | |

| City/Town | Province/State | Postal/Zip Code |
|---|---|---|
| | | |

What is the applicant's policy on devices returned to the applicant by clients?

◯Accept returns within the warranty period ◯Will not accept returns ◯Other

Provide an explanation of the vendor's policy on returns

## Authorizer Information

Under the Maxillofacial Extraoral Prostheses category, the applicant must employ at least one anaplastologist/restorative prosthetist or one prosthodontist with applicable experience. See the Guide to Vendor Registration Requirements, Part 7, for details.

Provide the name(s) and ADP registration number(s) of all ADP registered authorizers on staff. Note the profession of each authorizer.

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| Last Name | First Name |
|---|---|
| ADP Authorizer Number | Profession<br>☐Anaplastologist/Restorative Prosthetist ☐Prosthodontist |

**Location Details**

In order to be registered with ADP, the applicant's prosthetic location must have private assessment and fitting areas and standard equipment to design, fabricate, and fit maxillofacial extraoral prostheses.

◯Yes, all of these requirements are present.

◯No, these requirements are not present.

Provide an explanation

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# Vendor Registration Application
## Maxillofacial Intraoral Prostheses

Provide examples of the ADP listed devices that the applicant plans to sell or dispense under the Maxillofacial Intraoral Prostheses category.

Does the applicant provide instruction to clients on the use of the device?

◯Yes ◯No

Describe the process for ensuring that the client understands how to use the device

Does the applicant offer a follow-up service program to the client?

◯Yes ◯No

Describe the service

Provide an explanation

Is the applicant's repair service located on the applicant's premises?

◯Yes ◯No

**Provide Location**

Company Name

| Unit Number | Street Number | Street Name | PO Box |
|---|---|---|---|
| | | | |

| City/Town | Province/State | Postal/Zip Code |
|---|---|---|
| | | |

What is the applicant's policy on devices returned to the applicant by clients?

◯Accept returns within the warranty period ◯Will not accept returns ◯Other

Provide an explanation of the vendor's policy on returns

## Authorizer Information

Under the Maxillofacial Intraoral Prostheses category, the applicant must employ a prosthodontist or a general dentist with applicable experience. See the Guide to Vendor Registration Requirements, Part 7, for details.

Provide the name(s) and ADP registration number(s) of all ADP registered authorizers on staff. Note the profession of each authorizer.

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| Last Name | First Name | Middle Initial |
|---|---|---|
| | | |

| ADP Authorizer Number | Profession |
|---|---|
| | ☐Prosthodontist ☐General Dentist |

| | | |
|---|---|---|
| i. Is the general dentist working at a Cancer Care Centre? | ◯Yes | ◯No |
| ii. Does the general dentist have access to a prosthodontist for consultation? | ◯Yes | ◯No |
| iii. Is the general dentist affiliated with a hospital? | ◯Yes | ◯No |
| iv. Is the general dentist affiliated with a Faculty of Dentistry at a University? | ◯Yes | ◯No |

**Location Details**

In order to be registered with ADP, the applicant's prosthetic location must have private assessment and fitting areas and standard equipment to design, fabricate (if applicable), and fit maxillofacial intraoral prostheses.

◯Yes, all of these requirements are present.

◯No, these requirements are not present.

Provide an explanation

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Assistive Devices Program

# Vendor Registration Application

**Mobility Devices - Ambulation Aids**

List two (2) manufacturer lines of ADP listed devices that the applicant intends to offer for sale/dispense. Attach the manufacturer/distributor letters confirming that the applicant is an authorized dealer. See the Guide to Vendor Registration Requirements, Part 6, for details.

Manufacturer Name

Manufacturer Name

Is the applicant also the manufacturer/distributor of one or more ADP listed device(s) that the Vendor will be offering for sale/dispensing?

◯Yes ◯No

Is the applicant directly or indirectly owned or otherwise controlled by the manufacturer/distributor of the ADP listed device(s)?

◯Yes ◯No

Does the applicant provide instruction to clients on the use of the device?

◯Yes ◯No

Describe the process for ensuring that the client understands how to use the device

Does the applicant offer a follow-up service program to the client?

◯Yes ◯No

Describe the service

Provide an explanation

Does the applicant honour manufacturer warranties for the type(s) of ADP listed device(s) that will be offered for sale/dispensed?

◯Yes ◯No

Provide an explanation

Is the applicant's repair service located on the applicant's premises?

◯Yes ◯No

**Provide Location**

Company Name

| Unit Number | Street Number | Street Name | PO Box |
|---|---|---|---|
| | | | |

| City/Town | Province/State | Postal/Zip Code |
|---|---|---|
| | | |

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What is the applicant's policy on devices returned to the applicant by clients?

◯Accept returns within the warranty period ◯Will not accept returns ◯Other

Provide an explanation of the vendor's policy on returns

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Assistive Devices Program

# Vendor Registration Application

**Mobility Devices - Manual Wheelchairs**

List two (2) manufacturer lines of ADP listed devices that the applicant intends to offer for sale/dispense. Attach the manufacturer/distributor letters confirming that the applicant is an authorized dealer. See the Guide to Vendor Registration Requirements, Part 6, for details.

Manufacturer Name

Manufacturer Name

Is the applicant also the manufacturer/distributor of one or more ADP listed device(s) that the Vendor will be offering for sale/dispensing?

◯Yes ◯No

Is the applicant directly or indirectly owned or otherwise controlled by the manufacturer/distributor of the ADP listed device(s)?

◯Yes ◯No

Does the applicant provide instruction to clients on the use of the device?

◯Yes ◯No

Describe the process for ensuring that the client understands how to use the device

Does the applicant offer a follow-up service program to the client?

◯Yes ◯No

Describe the service

Provide an explanation

Does the applicant honour manufacturer warranties for the type(s) of ADP listed device(s) that will be offered for sale/dispensed?

◯Yes ◯No

Provide an explanation

Is the applicant's repair service located on the applicant's premises?

◯Yes ◯No

**Provide Location**

Company Name

| Unit Number | Street Number | Street Name | PO Box |
|---|---|---|---|
| | | | |

| City/Town | Province/State | Postal/Zip Code |
|---|---|---|
| | | |

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What is the applicant's policy on devices returned to the applicant by clients?

◯Accept returns within the warranty period ◯Will not accept returns ◯Other

Provide an explanation of the vendor's policy on returns

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Assistive Devices Program

# Vendor Registration Application

**Mobility Devices - Positioning Systems for Wheelchairs**

List two (2) manufacturer lines of ADP listed devices that the applicant intends to offer for sale/dispense. Attach the manufacturer/distributor letters confirming that the applicant is an authorized dealer. See the Guide to Vendor Registration Requirements, Part 6, for details.

Manufacturer Name

Manufacturer Name

Is the applicant also the manufacturer/distributor of one or more ADP listed device(s) that the Vendor will be offering for sale/dispensing?

◯Yes ◯No

Is the applicant directly or indirectly owned or otherwise controlled by the manufacturer/distributor of the ADP listed device(s)?

◯Yes ◯No

Does the applicant provide instruction to clients on the use of the device?

◯Yes ◯No

Describe the process for ensuring that the client understands how to use the device

Does the applicant offer a follow-up service program to the client?

◯Yes ◯No

Describe the service

Provide an explanation

Does the applicant honour manufacturer warranties for the type(s) of ADP listed device(s) that will be offered for sale/dispensed?

◯Yes ◯No

Provide an explanation

Is the applicant's repair service located on the applicant's premises?

◯Yes ◯No

**Provide Location**

Company Name

| Unit Number | Street Number | Street Name | PO Box |
|---|---|---|---|
| | | | |

| City/Town | Province/State | Postal/Zip Code |
|---|---|---|
| | | |

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What is the applicant's policy on devices returned to the applicant by clients?

◯Accept returns within the warranty period ◯Will not accept returns ◯Other

Provide an explanation of the vendor's policy on returns

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Ministry of Health

Assistive Devices Program

# Vendor Registration Application

**Mobility Devices - Power Wheelchairs including Scooters**

List two (2) manufacturer lines of ADP listed devices that the applicant intends to offer for sale/dispense. Attach the manufacturer/distributor letters confirming that the applicant is an authorized dealer. See the Guide to Vendor Registration Requirements, Part 6, for details.

Manufacturer Name

Manufacturer Name

Is the applicant also the manufacturer/distributor of one or more ADP listed device(s) that the Vendor will be offering for sale/dispensing?

◯Yes ◯No

Is the applicant directly or indirectly owned or otherwise controlled by the manufacturer/distributor of the ADP listed device(s)?

◯Yes ◯No

Does the applicant provide instruction to clients on the use of the device?

◯Yes ◯No

Describe the process for ensuring that the client understands how to use the device

Does the applicant offer a follow-up service program to the client?

◯Yes ◯No

Describe the service

Provide an explanation

Does the applicant honour manufacturer warranties for the type(s) of ADP listed device(s) that will be offered for sale/dispensed?

◯Yes ◯No

Provide an explanation

Is the applicant's repair service located on the applicant's premises?

◯Yes ◯No

**Provide Location**

Company Name

| Unit Number | Street Number | Street Name | PO Box |
|---|---|---|---|
| | | | |

| City/Town | Province/State | Postal/Zip Code |
|---|---|---|
| | | |

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What is the applicant's policy on devices returned to the applicant by clients?

◯Accept returns within the warranty period ◯Will not accept returns ◯Other

Provide an explanation of the vendor's policy on returns

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Ministry of Health

Assistive Devices Program

# Vendor Registration Application

**Ocular Prostheses**

Provide examples of the ADP listed devices that the applicant plans to sell or dispense under the Ocular Prostheses category.

Does the applicant provide instruction to clients on the use of the device?

◯Yes ◯No

Describe the process for ensuring that the client understands how to use the device

Does the applicant offer a follow-up service program to the client?

◯Yes ◯No

Describe the service

Provide an explanation

Is the applicant's repair service located on the applicant's premises?

◯Yes ◯No

**Provide Location**

Company Name

| Unit Number | Street Number | Street Name | PO Box |
|---|---|---|---|
| | | | |

| City/Town | Province/State | Postal/Zip Code |
|---|---|---|
| | | |

What is the applicant's policy on devices returned to the applicant by clients?

◯Accept returns within the warranty period ◯Will not accept returns ◯Other

Provide an explanation of the vendor's policy on returns

## Authorizer Information

Under the Ocular Prostheses category, the applicant must employ an Ocularist certified by the National Examining Board of Ocularists (NEBO). See the Guide to Vendor Registration Requirements, Part 7, for details.

Provide the name(s) and ADP registration number(s) of all ADP registered certified ocularists on staff.

| Last Name | First Name |
|---|---|
| | |

ADP Authorizer Number

## Staffing Information

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Does the applicant employ interns and/or technicians?

◯Yes ◯No

Does the certified ocularist provide onsite supervision for the interns/technicians?

◯Yes ◯No

## Location Details

In order to be registered with ADP, the applicant's prosthetic location must have private assessment and fitting areas and an assessment/fitting area that is separate from the fabrication space.

◯Yes, all of these requirements are present.

◯No, these requirements are not present.

Provide an explanation

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**Ministry of Health**

Assistive Devices Program

# Vendor Registration Application

**Orthotic Devices**

Provide examples of the ADP listed devices that the applicant intends to offer for sale/dispense under the Orthotic Devices category.

List two (2) manufacturer lines of components that the applicant intends to offer for sale/dispense. Attach the manufacturer/distributor letters confirming that the applicant is an authorized dealer. See the Guide to Vendor Registration Requirements, Part 6, for details.

Manufacturer Name

Manufacturer Name

Is the applicant also the manufacturer/distributor of one or more of the component(s) that the Vendor will be offering for sale/dispensing?

◯Yes ◯No

Is the applicant directly or indirectly owned or otherwise controlled by the manufacturer/distributor of the component(s)?

◯Yes ◯No

Does the applicant provide instruction to clients on the use of the device?

◯Yes ◯No

Describe the process for ensuring that the client understands how to use the device

Does the applicant offer a follow-up service program to the client?

◯Yes ◯No

Describe the service

Provide an explanation

Does the applicant honour manufacturer warranties for the component(s) that will be offered for sale/dispensed?

◯Yes ◯No

Provide an explanation

Is the applicant's repair service located on the applicant's premises?

◯Yes ◯No

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**Provide Location**

Company Name

| Unit Number | Street Number | Street Name | PO Box |
|---|---|---|---|
| | | | |

| City/Town | Province/State | Postal/Zip Code |
|---|---|---|
| | | |

What is the applicant's policy on devices returned to the applicant by clients?

◯Accept returns within the warranty period ◯Will not accept returns ◯Other

Provide an explanation of the vendor's policy on returns

## Authorizer Information

Under the Orthotic Devices category, the applicant must employ a certified orthotist who is certified by the Canadian Board for Certification of Prosthetists and Orthotists (CBCPO). See the Guide to Vendor Registration Requirements, Part 7, for details.

Provide the name(s) and ADP registration number(s) of all ADP registered certified orthotists on staff.

| Last Name | First Name |
|---|---|
| | |

ADP Authorizer Number

## Staffing Information

Does the applicant employ orthotic interns and/or orthotic technicians?

◯Yes ◯No

Does a Board Certified Orthotist provide direct supervision for the orthotic interns and/or orthotic technicians?

◯Yes ◯No

## Location Details

In order to be registered with ADP, the applicant's orthotic location must have transfer bars in the washrooms, parallel bars and a full length mirror in the fitting areas, a chair or examination table in the fitting areas, private assessment and fitting areas and separate assessment, fabrication, fitting and training areas.

◯Yes, all of these requirements are present.

◯No, these requirements are not present.

Provide an explanation

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Ministry of Health

Assistive Devices Program

# Vendor Registration Application

## Pressure Modification Devices

Specify the subcategory for which the applicant is applying.

☐Hypertrophic Scar Management

☐Lymphedema Management

Provide examples of the ADP listed devices that the applicant intends to offer for sale/dispense under the Pressure Modification Devices category.

Provide the manufacturer lines for each type of ADP listed device that the applicant intends to offer for sale/dispense. Attach the applicable manufacturer/distributor letters confirming that the applicant is an authorized dealer. See the Guide to Vendor Registration Requirements, Part 6, for details.

| Device Type | Manufacturer Lines | Number of Manufacturer Lines Required |
|---|---|---|
| Hypertrophic Scar Management Garments | | 1 |
| Lymphedema Management Garments | | 2 |
| Lymphedema Management Sleeves | | 1 |
| Lymphedema Management - Sequential Extremity Pumps | | 1 |

Is the applicant also the manufacturer/distributor of one or more ADP listed device(s) that the Vendor will be offering for sale/dispensing?

◯Yes ◯No

Is the applicant directly or indirectly owned or otherwise controlled by the manufacturer/distributor of the ADP listed device(s)?

◯Yes ◯No

Does the applicant provide instruction to clients on the use of the device?

◯Yes ◯No

Describe the process for ensuring that the client understands how to use the device

Does the applicant offer a follow-up service program to the client?

◯Yes ◯No

Describe the service

Provide an explanation

Does the applicant honour manufacturer warranties for the type(s) of ADP listed device(s) that will be offered for sale/dispensed?

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◯Yes ◯No

Provide an explanation

Is the applicant's repair service located on the applicant's premises?

◯Yes ◯No

**Provide Location**

Company Name

| Unit Number | Street Number | Street Name | PO Box |
|---|---|---|---|
| | | | |

| City/Town | Province/State | Postal/Zip Code |
|---|---|---|
| | | |

What is the applicant's policy on devices returned to the applicant by clients?

◯Accept returns within the warranty period ◯Will not accept returns ◯Other

Provide an explanation of the vendor's policy on returns

## Certified Fitter/Authorizer Information

Under the Pressure Modification Devices category, the applicant must employ a minimum of one certified fitter who has a certificate from one training program recognized by the ADP for each type of device/product they sell/dispense. For Orthotics for Burnscar Management, a Vendor must employ a certified orthotist who is certified by the CBCPO. See the Guide to Vendor Registration Requirements, Part 7, for details.

Provide the name(s) and ADP registration number(s) of all ADP registered authorizers on staff. This includes certified fitters and/or certified orthotists.

| Last Name | First Name |
|---|---|
| | |

ADP Authorizer Number

Is the applicant offering for sale/dispensing Hypertrophic Scar Management devices?

◯Yes ◯No

Clinic Name

Clinic Number

Is the applicant offering for sale/dispensing sequential extremity pumps for primary lymphedema management?

◯Yes ◯No

Clinic Name

Clinic Number

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## Location Details

In order to be registered with ADP, the applicant’s location must have private fitting room(s) with solid doors and each fitting room must be equipped with a fitting table, a chair and a mirror.

◯Yes, all of these requirements are present.

◯No, these requirements are not present.

Provide an explanation

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Ministry of Health

Assistive Devices Program

# Vendor Registration Application

## Respiratory Equipment and Supplies

Provide all of the manufacturer lines for each type of ADP listed device that the applicant intends to offer for sale/dispense. Attach the applicable manufacturer/distributor letters confirming that the applicant is an authorized dealer. See the Guide to Vendor Registration Requirements, Part 6, for details.

| Required Devices | Manufacturer/Distributor Lines |
|---|---|
| Continuous Positive Airway Pressure Systems | |
| Bi-level Positive Airway Pressure Systems | |
| Auto-titrating Positive Airway Pressure Systems | |
| Medication Compressors | |
| High Output Air Compressors | |
| Suction Units | |
| Apnea/Cardiorespiratory Monitors | |
| Airway Clearance Devices | |

Is the applicant also the manufacturer/distributor of one or more ADP listed device(s) that the Vendor will be offering for sale/dispensing?

◯Yes ◯No

Is the applicant directly or indirectly owned or otherwise controlled by the manufacturer/distributor of the ADP listed device(s)?

◯Yes ◯No

Does the applicant provide instruction to clients on the use of the device?

◯Yes ◯No

Describe the process for ensuring that the client understands how to use the device

Does the applicant offer a follow-up service program to the client?

◯Yes ◯No

Describe the service

Provide an explanation

Does the applicant honour manufacturer warranties for the type(s) of ADP listed device(s) that will be offered for sale/dispensed?

◯Yes ◯No

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Provide an explanation

Is the applicant's repair service located on the applicant's premises?

◯Yes ◯No

**Provide Location**

Company Name

| Unit Number | Street Number | Street Name | PO Box |
|---|---|---|---|
| | | | |

| City/Town | Province/State | Postal/Zip Code |
|---|---|---|
| | | |

What is the applicant's policy on devices returned to the applicant by clients?

◯Accept returns within the warranty period ◯Will not accept returns ◯Other

Provide an explanation of the vendor's policy on returns

## Employee Qualifications

Under the Respiratory Equipment and Supplies category, the applicant must have staff trained in the use of respiratory equipment and who are able to provide education to clients. Complete this section for each staff member with applicable experience in the Respiratory Equipment and Supplies category who is employed by the applicant. Each employee to whom this applies is required to sign this section of the form.

**Employee Information**

| Last Name | First Name |
|---|---|
| | |

| Position | Length of employment with current employer |
|---|---|
| | |

Describe the employee's training and experience with clients and with respiratory equipment and supplies. Attach applicable documents to provide proof of course completion and/or qualifications.

**Employee Authorization**

The Ministry's collection of any personal information as part of this form is necessary for the proper administration of the Assistive Devices Program, which is authorized under the *Ministry of Health and Long-Term Care Act*, R.S.O. 1990, c. M.26, paragraph 4 of s. 6(1). Any personal information collected by the Ministry will be used in order to determine eligibility for registered vendor status under the Assistive Devices Program.

For further details concerning the Ministry's collection and use of this information, please contact the Registration Unit, Assistive Devices Program, 5700 Yonge Street, 7th floor, Toronto ON M2M 4K5. Telephone Number 416-327-8804; Toll free 1-800-268-6021; Email: adp@ontario.ca

I certify that all the answers and information provided to the Ministry as part of this Application are, to the best of my knowledge, true and accurate at the time of this Application and undertake to advise the Ministry forthwith of any changes that I become aware of. I understand that this information is subject to audit.

| Signature | Date (yyyy/mm/dd) |
|---|---|
| | |

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Ministry of Health

Assistive Devices Program

# Vendor Registration Application

**Teletypewriters for the Deaf or Speech Impaired (TTYs)**

Provide examples of the ADP listed devices that the applicant intends to offer for sale/dispense under the TTY category.

List two (2) manufacturer lines for ADP funded devices that the applicant carries. Attach the manufacturer/distributor letters confirming that the applicant is an authorized dealer. See the Guide to Vendor Registration Requirements, Part 6 for details.

| Manufacturer Name | Make | Model |
|---|---|---|
| | | |
| Manufacturer Name | Make | Model |
| | | |

Is the applicant also the manufacturer/distributor of one or more ADP listed device(s) that the Vendor will be offering for sale/dispensing?

◯Yes ◯No

Is the applicant directly or indirectly owned or otherwise controlled by the manufacturer/distributor of the ADP listed device(s)?

◯Yes ◯No

Does the applicant provide instruction to clients on the use of the device?

◯Yes ◯No

Describe the process for ensuring that the client understands how to use the device

Does the applicant offer a follow-up service program to the client?

◯Yes ◯No

Describe the service

Provide an explanation

Does the applicant honour manufacturer warranties for the type(s) of ADP listed device(s) that will be offered for sale/dispensed?

◯Yes ◯No

Provide an explanation

Is the applicant's repair service located on the applicant's premises?

◯Yes ◯No

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**Provide Location**

Company Name

| Unit Number | Street Number | Street Name | PO Box |
|---|---|---|---|
| | | | |

| City/Town | Province/State | Postal/Zip Code |
|---|---|---|
| | | |

What is the applicant's policy on devices returned to the applicant by clients?

◯Accept returns within the warranty period ◯Will not accept returns ◯Other

Provide an explanation of the vendor's policy on returns

List all makes and models of ADP listed TTYs and flashing signaling devices available at the applicant's premises for demonstration to clients.

Indicate communication skills of the applicant's staff with clients who are deaf:

| | | |
|---|---|---|
| Speech | ◯Yes | ◯No |
| American Sign Language | ◯Yes | ◯No |
| Written Notes | ◯Yes | ◯No |

## Employee Qualifications

Under the TTY category, the applicant must employ staff who have experience with TTY and flashing signaling devices and in working with clients who are deaf or have speech impairments. See the Guide to Vendor Registration Requirements, Part 7, for details. Complete this section for each staff member with applicable experience in the TTY category who is employed by the applicant. Each employee to whom this applies is required to sign this section of the form.

**Employee Information**

| Last Name | First Name |
|---|---|
| | |

| Position | Length of employment with current employer |
|---|---|
| | |

Describe the employee's training and experience with clients and with TTYs and flashing signaling devices. Attach applicable documents to provide proof of course completion and/or qualifications.

**Employee Authorization**

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I certify that all the answers and information provided to the Ministry as part of this Application are, to the best of my knowledge, true and accurate at the time of this Application and undertake to advise the Ministry forthwith of any changes that I become aware of. I understand that this information is subject to audit.

| Employee Signature | Date (yyyy/mm/dd) |
|---|---|
| | |

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Ministry of Health

Assistive Devices Program

# Vendor Registration Application

## Visual Aids

Specify which type of visual aids the applicant intends to dispense:

☐Low Technology

☐High Technology

Provide examples of the ADP listed devices that the applicant plans to sell or dispense under the Visual Aids category. Include the make and model for each example. Refer to the Visual Aids Product Manual.

List two (2) manufacturer lines of ADP listed devices that the applicant carries. Attach the manufacturer/distributor letters confirming that the applicant is an authorized dealer. See the Guide to Vendor Registration Requirements, Part 6, for details.

| Manufacturer Name | Make | Model |
|---|---|---|
| | | |
| Manufacturer Name | Make | Model |
| | | |

Is the applicant also the manufacturer/distributor of one or more ADP listed device(s) that the Vendor will be offering for sale/dispensing?

◯Yes ◯No

Is the applicant directly or indirectly owned or otherwise controlled by the manufacturer/distributor of the ADP listed device(s)?

◯Yes ◯No

Does the applicant provide instruction to clients on the use of the device?

◯Yes ◯No

Describe the process for ensuring that the client understands how to use the device

Does the applicant offer a follow-up service program to the client?

◯Yes ◯No

Describe the service

Provide an explanation

Does the applicant honour manufacturer warranties for the type(s) of ADP listed device(s) that will be offered for sale/dispensed?

◯Yes ◯No

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Provide an explanation

Is the applicant's repair service located on the applicant's premises?

◯Yes ◯No

**Provide Location**

Company Name

| Unit Number | Street Number | Street Name | PO Box |
|---|---|---|---|
| | | | |

| City/Town | Province/State | Postal/Zip Code |
|---|---|---|
| | | |

What is the applicant's policy on devices returned to the applicant by clients?

◯Accept returns within the warranty period ◯Will not accept returns ◯Other

Provide an explanation of the vendor's policy on returns

## Employee Qualifications - Authorizers

Applicants wishing to vend prescriptive optical aids, and who have on staff optometrists or ophthalmologists who are registered as ADP authorizers, must provide the staff members' name(s) and ADP authorizer numbers.

**Authorizers**

☐Not applicable

| Name | ADP Authorizer Number |
|---|---|
| | |

## Employee Qualifications - General Staff

Under the Visual Aids category, the applicant must have staff who are trained in the use and repair of specialized visual aids and/or computer systems and who have experience in working with clients who are blind or visually impaired. See the Guide to Vendor Registration Requirements, Part 7, for details. Complete this section for each staff member with applicable experience in the Visual Aids category who is employed by the applicant. Each employee to whom this applies is required to sign this section of the form.

**Employee Information**

| Last Name | First Name |
|---|---|
| | |

| Position | Length of employment with current employer |
|---|---|
| | |

Describe the employee's training and experience with clients and with visual aids. Attach applicable documents to provide proof of course completion and/or qualifications.

**Employee Authorization**

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| Signature | Date (yyyy/mm/dd) |
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