

INFORMATION ACCESS REQUEST FORM

PLEASE SUBMIT THIS COVERSHEET WITH ALL ACCESS REQUESTS-BOTH NEW IDS AND UPDATES

Please complete all of the information below. Incomplete forms will be rejected.

TODAY'S DATE: _____ START DATE: _____

USER'S NAME: _____
LAST NAME FIRST NAME MIDDLE INITIAL

LAST 4 DIGIT'S OF THE USER'S SSN: _____

DEPARTMENT NAME: _____

NETWORK USER ID: _____

EMPLOYEE'S TITLE: _____

PRIMARY WORK LOCATION: _____
(UH, UHCD, UFHCN, UFHCNW, UFHCWSW, UFHCSE, UHBC, UCCH, DHCS, UTHSC, CTRC, UPG, ETC.)

RC NUMBER: _____

PHONE EXT./PAGER NBR: _____

CREDENTIAL: _____ (MD, PA, MS3, MS4, RN, CRRT, LVN, etc.)

MEDICAL-DENTAL STAFF\ALLIED HEALTH ID#: _____

FACULTY HOUSESTAFF/RESIDENT Military Rotator (_____ to _____)

ALLIED HEALTH W/ PRESCRIPTIVE AUTHORITY

Visiting Medical Student (_____ to _____) Authorization letter from UT Registrar's office must be attached.
Requests without authorization will be rejected.

Contract/temporary (_____ to _____)

Researcher or Research Monitor (_____ to _____) for IRB# _____

AUTHORIZATION:
(DIRECTOR/SUPERVISOR)

PRINT: _____
NAME TITLE

SIGNATURE: _____

E-MAIL ADDRESS FOR NOTIFICATION: _____
(not required if your email is @uhs-sa.com)

Have any questions? Call Data Security at 358-0640. You may route completed access forms to us at MS124-1, fax them to us at 358-0340, or bring them by the Computer Room on the 1st floor of the Hospital 24-hours a day.

**INFORMATION ACCESS REQUEST FORM
EMTEK ACCESS**

USER'S NAME: _____

LOGIN ID (IF KNOWN): _____

SUPERVISOR'S SIGNATURE: _____

ISSUE NEW ID

UPDATE EXISTING ID

DELETE EXISTING ID

USER CLASSIFICATIONS

<p>FULL DOCUMENTATION ACCESS</p> <p><input type="checkbox"/>Physician (Attending, Resident, Consulting)</p> <p><input type="checkbox"/>Staff Nurse (RN, LVN, GN, MSN, ETC.)</p> <p><input type="checkbox"/>Pharmacist</p> <p><input type="checkbox"/>Clinical Nurse Specialist</p> <p><input type="checkbox"/>Clinical Nursing Director</p> <p><input type="checkbox"/>Physical Therapist</p> <p><input type="checkbox"/>Respiratory Therapist (RT, CRRT, ETC.)</p> <p><input type="checkbox"/>Social Worker</p> <p><input type="checkbox"/>Quality/Risk Management (RN, MSN, ETC.)</p> <p><input type="checkbox"/>UR/Infection Control</p> <p><input type="checkbox"/>Dietician</p>	<p>CONTROLLED DOCUMENTATION ACCESS</p> <p><input type="checkbox"/>Attendant</p> <p><input type="checkbox"/>Clerk</p> <p><input type="checkbox"/>Patient Care Associate</p> <p><input type="checkbox"/>Secretary</p> <p><input type="checkbox"/>Technician</p> <p><input type="checkbox"/>Student (ALL TYPES)</p>
	<p align="center">REVIEW ONLY</p> <p><input type="checkbox"/>Instructor</p>
	<p align="center">SYSTEM ADMINISTRATION ACCESS</p> <p><input type="checkbox"/>IS Staff (Emtek Support)</p>

<p>FOR OFFICE USE:</p> <p>DATE COMPLETED: _____</p> <p>COMPLETED BY: _____</p>
