Regional System Access Request Request Date (dd/mm/yy) _____

Applicant Information

Hospital Name: _____ Network login name: _____

Legal Name: _____ _____ _____ _____

Last Given Middle Preferred Name

Dept/Prog/Location:_____ Phone No:_____Ext._____

Position/Job Title: _____ Email:_____ Pager #_____

Day/Month of Birth: dd ____ mm_____

Decribe your relationship to the hospital:

☐ Physician with privileges: OHIP Billing #:_____

☐ Employee of hospital: Employee ID # (from pay stub)_____

☐ 3rd party employee: Name of employer/agency:_____ Driver's license #_____

☐ Student: Area of Study/School_____ Student ID #_____

☐ Other specify_____

_____ Driver's license #_____

If applicant is a student or 3rd party employee indicate dd/mm/yy this individual is expected to leave_____

Are you employed by or currently have privileges at another hospital?

☐ No ☐ Yes – List hospitals:_____

Do you have a login account at any of these hospitals? Yes ☐ No ☐

Reason for request: ☐ Clinical Care ☐ Research ☐ 3rd party work ☐ Other_____

If this is a request for research/3rd party work, describe nature of work (include title of research project), the reason for the request and what type of information is needed (e.g., laboratory results).

_____

_____

_____

_____

Research: Research "R" # _____

Systems required to access:

☐ Cerner ☐ Other _____

Authorizing Information

Department/Area Leader Requesting System Access (or Principal Investigator if this is a research request).

I certify that the information submitted on this System Access Request Form is accurate and complete and that the applicant requires access as requested to perform his/her functions and duties at this hospital.

_____ _____ _____

Print Name Signature Title

_____ _____ _____ _____ _____

Dept/Program/Location Phone # Ext. Email Date (dd/mm/yy)