



Clinical Access Authorization Form

FAX to: 1-866-634-8489

Last Name:		First Name:		MI:
Office / Work Name:		Office / Work Phone:	Ext:	Office / Work Fax:
Office / Work Address (include Suite #):		City, State, Zip Code		
Date of Birth: (required)	Full SSN#: (required)	Pager #:	E-mail Address:	

Access Requested: Please Check any that apply: <input type="checkbox"/> AD/NT <input type="checkbox"/> Muse (EKG) <input type="checkbox"/> Meditech <input type="checkbox"/> PACS <input type="checkbox"/> Electronic Signature / Edit <input type="checkbox"/> Remote Access (SRA / VDI) <input type="checkbox"/> Mobility (iPHONE) <input type="checkbox"/> Portal (web access Meditech) <input type="checkbox"/> GECPN Access (QS-Perinatal) <input type="checkbox"/> GECPN/OB Link MD only-Facility Approval <input type="checkbox"/> T Systems (ED) <input type="checkbox"/> Clinicomp (ICU for Swedish only) <input type="checkbox"/> Accudose/Pyxis (ANES ONLY) <input type="checkbox"/> Other	<input type="checkbox"/> HealthONE Credentialed Provider Please Check One: <input type="checkbox"/> Doctor <input type="checkbox"/> Allied Health Professional LIC# _____ <input type="checkbox"/> Office Staff of Credentialed Doctor <input type="checkbox"/> Clinical <input type="checkbox"/> Non- Clinical Job Title: _____ Providers/Group Name _____	<input type="checkbox"/> Non-HealthONE Credentialed Provider Please Check One: <input type="checkbox"/> Doctor <input type="checkbox"/> Allied Health Professional LIC# _____ <input type="checkbox"/> Resident Grad Date: _____ <input type="checkbox"/> Intern Grad Date: _____ <input type="checkbox"/> Med Student End Date: _____ <input type="checkbox"/> Office Staff of Non-Credentialed Doctor <input type="checkbox"/> Clinical <input type="checkbox"/> Non- Clinical Providers/Group Name _____
	Action Requested: <input type="checkbox"/> New <input type="checkbox"/> Add <input type="checkbox"/> Reactivate <input type="checkbox"/> Change	Primary Facility (if applicable): <input type="checkbox"/> North Suburban Medical Center <input type="checkbox"/> Rose Medical Center <input type="checkbox"/> Swedish Medical Center <input type="checkbox"/> The Medical Center of Aurora <input type="checkbox"/> P/SL Medical Center <input type="checkbox"/> Spalding Rehabilitation Hospital <input type="checkbox"/> Sky Ridge Medical Center <input type="checkbox"/> Swedish Southwest ER <input type="checkbox"/> Centennial Medical Plaza <input type="checkbox"/> All

I understand the password for accessing the above designated application(s) is to be held in STRICT CONFIDENCE. I also understand willful disclosure of my password or any other user's password or misuse of any password will be considered grounds for termination of access and if applicable, company employment, privileges or engagement.

User Signature:	Date:	Physician Signature for Office Staff:
		Physician's Printed Name

FOR SECURITY COORDINATOR/DESIGNEE ONLY

LSC / Designee Signature	Date:	Meditech ID/Mnemonic:
LSC / Designee Signature	Date:	User 3/4 ID:
LSC / Designee Signature	Date:	Physician Relations Manager Signature