

The Valley Health System

3RD PARTY COMPUTER ACCESS REQUEST

REQUESTOR: Complete and Fax to VHS Information Services (702) 853-8953. Please PRINT all information.

Requestor Last Name	First Name	Initial	Requestor Cell Phone #
			(Cell Phone number required to receive 2-Factor Authorization text code to access Cerner.)
** You must enter either a FAX number or an Email in order to receive your login ID **			
Requestor Complete FAX #:		Requestor Email Address:	
Name of Group/Company/Physician Practice:		Telephone #:	Purpose of Access Request: <i>(Please be detailed. In accordance with HIPAA Privacy Rule, access is granted on a Need-To-Know basis.)</i>
Office Supervisor Name:		Office Supervisor Telephone #:	
Office Supervisor Email Address:			
** To Be Completed by Provider/Case Management RN **			
State License #:		Specialty:	
Select the Hospital Access Needed For:			
<input type="checkbox"/> Centennial	<input type="checkbox"/> Desert Springs	<input type="checkbox"/> Henderson	<input type="checkbox"/> Summerlin
		<input type="checkbox"/> Spring Valley	<input type="checkbox"/> Valley
		<input type="checkbox"/> Valley Health Specialty Hospital	
Select Appropriate Type of Access Needed:		Second Level Approval Signature (VHS I.S. to Obtain):	
<input type="checkbox"/> Physician <input type="checkbox"/> AHP <input type="checkbox"/> Medical Scribe <input type="checkbox"/> Student Medical		N/A	
<input type="checkbox"/> Government Agency <input type="checkbox"/> HIM Reviewer <input type="checkbox"/> Insurance		HIM Management:	
<input type="checkbox"/> Medical/Legal (Attorney) <input type="checkbox"/> Physician Office Staff			
<input type="checkbox"/> Other: _____			
<input type="checkbox"/> Case Manager <input type="checkbox"/> Other: _____		Case Management:	
How you will access the system:		Access START Date:	Access END Date:
<input type="checkbox"/> Onsite (on site at the hospital)			
<input type="checkbox"/> Remote (off site from the hospital)			
<input type="checkbox"/> Both			
APPLICATIONS REQUESTED (Check All That Apply):			
<input checked="" type="checkbox"/> VHS Network Access (required for any access)			
<input checked="" type="checkbox"/> CERNER	<input type="checkbox"/> Dragon Direct	<input type="checkbox"/> Fetalink (OB Docs)	<input type="checkbox"/> Fetalink+ (iPhone App)
<input type="checkbox"/> Radiology PACS	<input type="checkbox"/> Cardiology PACS	<input type="checkbox"/> MUSE (For Cardiologists Only)	
<input type="checkbox"/> Other (Please Specify): _____			
Requestor Signature:		Date:	

Please select all applications required. Please submit the [VHS Data Access Agreement Form](#) along with this form.

For any questions or concerns, please contact the Helpline at 702-369-7788.