

# The Valley Health System

## 3RD PARTY COMPUTER ACCESS REQUEST

**REQUESTOR: Complete and Fax to VHS Information Services (702) 853-8953.**

Please **PRINT** all information.

<b>Requestor Last Name</b>	<b>First Name</b>	<b>Initial</b>	<b>Requestor Contact Phone #</b>
<p><b>** You must enter either a FAX number or an Email in order to receive your login ID **</b></p> <p><b>Requestor Complete FAX #:</b> _____ <b>Requestor Email Address:</b> _____</p>			
<b>Name of Group/Company/Physician Practice:</b>		<b>Telephone #:</b>	
<b>Office Supervisor Name:</b>		<b>Telephone #:</b>	
<p><b>** To Be Completed by Provider/Case Management RN **</b></p> <p><b>State License #:</b> _____ <b>Specialty:</b> _____</p>			
<b>Select the Hospital Access Needed For:</b>			
<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		
<b>Select Appropriate Type of Access Needed:</b>		<b>Second Level Approval Signature (VHS I.S. to Obtain):</b>	
<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 <input type="checkbox"/> Medical/Legal (Attorney) <input type="checkbox"/> Physician Office Staff <input type="checkbox"/> Other: _____		HIM Management:	
<input type="checkbox"/> Case Manager <input type="checkbox"/> Other: _____		Case Management:	
<b>How you will access the system:</b>		<b>Access START Date:</b>	<b>Access END Date:</b>
<input type="checkbox"/> Onsite (on site at the hospital) <input type="checkbox"/> Remote (off site from the hospital) <input type="checkbox"/> Both			
<b>APPLICATIONS REQUESTED (Check All That Apply):</b>			
<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): _____			
<b>Requestor Signature:</b>		<b>Date:</b>	

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

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