



IPM 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.)
<p>** You must enter either a FAX number or an Email in order to receive your login ID **</p> <p>Requestor Complete FAX #: _____ Requestor Email Address: _____</p>			
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:			
Select the Hospital Access Needed For:			
<input type="checkbox"/> IPM Clinics			
Select Appropriate Type of Access Needed:		Second Level Approval Signature (VHS I.S. to Obtain):	
<input type="checkbox"/> Physician Office Staff		HIM Management:	
<input type="checkbox"/> Other: _____			
How you will access the system:		Access START Date:	Access END Date:
<input type="checkbox"/> Remote (off site from the hospital)			
APPLICATIONS REQUESTED (Check All That Apply):			
<input checked="" type="checkbox"/> VHS Network Access (required for any access)			
<input checked="" type="checkbox"/> CERNER			
Requestor Signature:		Date:	
Please select all applications required. Please submit the VHS Data Access Agreement Form along with this form.			