Methodist University Hospital
Information Systems Access Request: Resident/Fellow

Please return forms to Lori.Kessler@mlh.org
- Training on system use is mandatory prior to account activation.
- **INCOMPLETE FORMS WILL NOT BE PROCESSED**
- If form is handwritten, it must be **clear and legible**. **DO NOT** WRITE IN CURSIVE.

Check one:
- ☐ NEW ACCESS REQUEST
- ☐ VISITING RESIDENT/FELLOW
- ☐ REQUEST TO CHANGE EXISTING ACCESS (circle changes below)

Legal Last Name: _____ **Legal First Name:** _____

Middle Name: _____ **Degree/Credentials:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Primary Phone: _____ **Pager:** _____

Email Address: _____

SS#: _____ – _____ – _____ **ECFMG # (n/a if not needed):** _____

Date of Birth: _____ ☐ **M** ☐ **F** **NPI:** _____

☐ **Resident** ☐ **Fellow** **ACGME Program Name:** _____

Start Date: _____ **End Date:** _____ **Current PGY:** _____

Parent Institution: ☐ UT ☐ St. Jude ☐ Baptist ☐ Tupelo ☐ Other: _____

License # (if applicable): _____

Fax # for Medical Information: _____ **Fax# for Physician Communication:** _____

Please provide a secret question and answer the Information Systems Help Desk can use to identify you over the phone. The answer should only be known to you.

Identifying Question: _____

Response: _____

Confidentiality Agreement:
You are authorized to access and utilize certain data and information only for the patients you are studying in the course of your medical education program at Methodist Healthcare. When in doubt as to whether or not information should be obtained, it is your responsibility to discuss the matter with your supervising physician. Each time you access a patient's records your entry will be identified with you and permanently recorded. By affixing your signature below, you agree to follow any and all applicable policies and procedures implemented by Methodist Healthcare regarding the privacy and security of protected health information as that term is defined in 45 C.F.R. Parts 160 and 164. You also agree to take responsibility for the confidentiality of your passwords to gain access to such information. You also agree to comply with all applicable federal and state laws, rules and regulations, including, but not limited to, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") regarding the privacy and security of such information.

Resident/Fellow Signature: _____ **Date:** _____

****Do not write in this area****

Physician ID: _____ **Cerner Role:** _____

_____ _____
Director/VP Signature **Date**

Remedy Ticket #: _____ **Login ID:** _____

Completed by: _____ **On Date:** _____

Revised 07/01/2018