

Access Request: Resident Physician

Purpose: This form is used for Cerner Resident/Fellow access.

- **Residents, Fellows please fax forms to Medical Education at 516-8254.**
- **Training on system use is mandatory prior to account activation. Please contact a physician analyst for training.**

Legal Name (Last, First, MI) _____ Phone # ____/____/____ - _____
(Please Print)

Pager/Cellular # ____/____/____ - _____

Social Security # _____ Birth Date _____

E-mail Address _____

Address _____

Primary Methodist Hospital(s) _____

Practice Affiliation/Name of Practice Group _____

Address _____ Suite/Office # _____

City/State/Zip _____ Practice Phone # ____/____/____ - _____

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

Rotation type _____ Start date ____/____/____ End date ____/____/____

As a security precaution, the following password will only be used to access the system for the first time. After you have successfully logged into the system you will be prompted to change your password.

Initial Password _____ (Must be at least 8 alpha numeric characters)

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 your patients and authorized consults. 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 and shall require all of your employees and Business Associates to comply, with all applicable federal and state laws, rules and regulations, including, but not limited to, the Health Insurance and Portability and Accountability Act of 1996 ("HIPAA") regarding the privacy and security of such information.

Physician's Name _____ Signature _____ Date ____/____/____
(REQUIRED) (Please Print)

For Medical Staff Service Use Only

1. Physician ID _____ Resident Pediatric Resident Fellow

2. Cerner Role: _____

3. If applicable, please check:

Cardiology Resident/Fellow CV Surgery Resident/Fellow Neurosurgery Resident/Fellow

Pathology Resident/Fellow Radiology Resident/Fellow

4. If this is a request to change information, please note the changes here _____

5. Director/VP Signature _____ Date ____/____/____

Revised 12/08/06