UCLA MEDICAL CENTER **Medical Information TechnologyServices / 176746** 10880 Wilshire Blvd., Suite 600 Los Angeles, CA 90024 Phone: (310) 267-4560 / Fax: (310) 794-7895	**ACCESS REQUEST FORM**	**MCCS USE ONLY** **USER ID:**

PLEASE TYPE (or print legibly) REQUIRED INFORMATION BELOW.

(1) NAME (Last/First/Initial) **[REQUIRED]**	(2) TITLE **PHYSICIAN**	(3) TELEPHONE (Work) **[REQUIRED]** **(310) 825-8307**
(4) ORGANIZATION AND MAILING ADDRESS **[REQUIRED]** (room number and building or street address, city, state & zip) **B713 RR 741930**	(5) MOTHER'S MAIDEN NAME OR IDENTIFYING WORD **[REQUIRED]**	

(6) EMPLOYEE ID	(7) BARGAINING UNIT	(8) 4-DIGIT TITLE CODE

(9) SELECT THE DEPARTMENT **[REQUIRED]**

- ☐ Department of Medicine
- ☐ Anesthesiology
- ☐ Obstetrics and Gynecology
- ☐ Pediatrics
- ☐ Surgery
- ☐ Family Health
- ☐ Midwives
- ☐ Neurology
- ☐ Psychiatry

ACCESS PROVIDED: AD domain, Exchange email, physician RACF/mainframe access, and CliniComp Essentris.

- ☐ Dentistry
- ☐ Ophthalmology
- ☐ Pathology
- ☐ Radiology

ACCESS PROVIDED: AD domain, Exchange email, and physician RACF/mainframe access.

(10) OTHER DEPARTMENT OR OTHER ACCOUNT(S) REQUESTED:

Please select one or more of the following if the desired access or department is different than listed above.

- ☐ Department: _____

Please specify the requested access

- ☐ CliniComp Essentris
- ☐ RACF/ mainframe
- ☐ AD domain
- ☐ Exchange Email
- ☐ FoRMs Portal Access Level: _____

NOTES, COMMENTS, REQUESTS:

(11) **UNAUTHORIZED COMPUTER USE:**

I, the undersigned, acknowledge that the computer systems at UCLA Health System provide me the capacity to authenticate and date my approval of medical record documents by means of Electronic Signature. My signature below verifies this acknowledgment and authorizes this Electronic Signature to represent my written signature. I will not delegate the use of my Electronic Signature or allow another individual to utilize my password. I understand that once a report is electronically signed, no modifications may be made. Any corrections, additions, or deletions must be made via a dictated addendum.

In agreeing to the above, I understand that my Electronic Signature is authentic, confidential and is compliant with the Management of Information Standards of the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) and Title 22 of the California Administrative Code.

UNAUTHORIZED COMPUTER USE: Unauthorized use of Medical Enterprise computer equipment and or data could result in University disciplinary action (up to and including termination), and may constitute grounds for either civil action(for restitution) or criminal prosecution.

I HAVE READ AND UNDERSTOOD THE ABOVE STATEMENTS:

_____ Applicant Signature **[REQUIRED]** _____ Date**[REQUIRED]**

(12) AUTHORIZER **[REQUIRED]**

_____ / **Sharina Kumar** _____ _____

Signature Print Name Date

MCCS USE ONLY

Completed By:	**Date:**