

Please email this completed form to KGH IT Access -> ACCESS@KGH.KARI.NET

Reason for This Request

- ☐ New Hire /
☐ Job/Department Change
☐ Name Change
☐ Resignation/Termination
☐ Change Access
☐ Change Admitting Privileges
☐ Change Expiry Date

Status: ☐ Full Time ☐ Part Time ☐ Temp ☐ Contract ☐ Casual

Site:

- ☐ KGH ☐ KRCC
☐ PCCC ☐ HDH

Other _____

Requested by Date: ____/____/____
Year Month Day

Access Expiry Date: ____/____/____
Year Month Day

Phone: _____

CPSO #: _____

Legal First Name: _____ Last Name: _____ Job Title: _____

Department / Specialty: _____ Office Address: _____

If access should mirror another employee, please indicate their name or user ID: _____

Departmental shared drive name: _____

Shared Mailbox or Email Distribution group name(s): _____

Computer Access

System(s) to access: Please check each that would apply

- | | | |
|----------------------------------------------------|-----------------------------------------------|----------------------------------------|
| <input type="checkbox"/> Patient Care System (PCS) | <input type="checkbox"/> EDIS | <input type="checkbox"/> Vocera |
| <input type="checkbox"/> Emerald | <input type="checkbox"/> OR Manager | <input type="checkbox"/> Omnicell |
| <input type="checkbox"/> Email | <input type="checkbox"/> Sunquest Labs | <input type="checkbox"/> EntryPoint |
| <input type="checkbox"/> SAP – Cost Centre _____ | <input type="checkbox"/> Remote Citrix Access | <input type="checkbox"/> Payroll (HDH) |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Other _____ | <input type="checkbox"/> Other _____ |

If the employee needs access to PCS, please indicate what level of access is required below

- | | |
|---------------------------------------------|---------------------------------------------------|
| <input type="checkbox"/> Medical Student | <input type="checkbox"/> Clinical Clerk |
| <input type="checkbox"/> Clinical Associate | <input type="checkbox"/> Resident |
| <input type="checkbox"/> Observer | <input type="checkbox"/> Consultant |
| <input type="checkbox"/> Fellow | <input type="checkbox"/> Attending Physician |
| <input type="checkbox"/> PGY | <input type="checkbox"/> Other as described _____ |
| <input type="checkbox"/> Associate | |

Administrative Authorization

Managers Name (print): _____ Date: _____

Administrative Authorization / Managers Signature: _____

Please complete all questions on this form as completely and accurately as possible to insure that your request for access is processed in a timely manner. Incomplete forms will be returned to the originating department.

Authorization must come from the applicant's supervisor or appropriate administration. Applicants may not authorize themselves.

If you have any questions or concerns regarding the completion of this form please contact the KGH Customer Support Desk at 4357.