ACCOUNT REQUEST FORM

For all Non-LVMC Employed Users

To receive access to LVMC systems (such as our EHR, PACS or RIS), fill-out the form below and return it, along with a signed LVMC Confidentiality Agreement to:

Information Systems
Fax: (805) 737-5770
Tele: (805) 737-5751
Email: support@lompocvmc.com

YOUR PERSONAL INFORMATION:

LAST NAME:______________________ FIRST NAME:____________________ MI: ____ SUFFIX: ______

EMAIL: ____

Provide a secret question and answer, they will be used to verify your identity over the phone.

SECRET QUESTION: ______________________ SECRET ANSWER: _____________________________

☐ A **COLOR** copy of a GOVERNMENT ISSUED IDENTIFICATION is required if you do not have a clinical license.*

HEALTHCARE PROFESSIONALS ONLY:

DISCIPLINE: ____

LICENSE*: ____________________________ DEA: _________________________ NPI: ______________

OFFICE, PRACTICE OR PHYSICIAN YOU WORK FOR:

OFFICE NAME: ____

ADDRESS: _________________________ CITY: _____________________________ STATE: ___________

PHONE:_____________________________ FAX: _____________________________

YOUR SUPERVISOR:

A SIGNATURE FROM YOUR OFFICE MANAGER OR SUPERVISOR IS REQUIRED:

NAME: _____________________________ SIGNATURE: ______________________ DATE: ___________

PHONE: ____________________________ EMAIL: _____________________________________

LVMC SPONSOR

NAME: _____________________________ SIGNATURE: ______________________ DATE: ___________

LVMC USE ONLY:

USER NAME: ____ AFFINITY # ___________

REVIEWED BY:________________________ SIGN:______________________ DATE: ___________

APPROVED BY:________________________ SIGN:______________________ DATE: ___________

COMPLETED: ☐ BAA ☐ INFORMATION SECURITY AGREEMENT ☐ CONFIDENTIALITY AGREEMENT

ACCOUNTS: ☐ PORTAL ☐ SCM ☐ AFFINITY ☐ PACS/RIS ☐ QUICKCHART ☐ ACTIVE DIRECTORY