WESLEY MEDICAL CENTER
Physician User ID Request

TO BE COMPLETED BY PHYSICIAN (please print)

_____ _____ _____ _____
Last **First** **MI** **D.O.B**

Office Phone _____ **Social Security #** _____

Office Name _____

Office Address _____

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

_____ **Meditech** _____ **Radiology PACS** _____ **CV PACS**

_____ **GE QS Fetal Monitoring** _____ **Secure ID Card** (High Speed Remote Accecss)

Comments _____

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USERS AGREEMENT

I UNDERSTAND THAT I AM BEING GIVEN ACCESS TO THE WESLEY MEDICAL CENTER COMPUTING EQUIPMENT. I AGREE NOT TO SHARE MY USER ID AND PASSWORD WITH ANY OTHER PERSON. I FURTHER UNDERSTAND THAT I AM RESPONSIBLE FOR ANY ACTIVITY PERFORMED UNDER MY USER ID. I UNDERSTAND THAT VIOLATIONS OF THIS AGREEMENT COULD LEAD TO DENIAL OF ACCESS TO THE WESLEY MEDICAL CENTER COMPUTER SYSTEM(S).

>_____ _____
PHYSICIAN SIGNATURE **DATE**

RETURN ALL COPIES TO INFORMATION SERVICES

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FOR USE BY SECURITY ADMINISTRATOR

_____ _____
SECURITY ADMINISTRATOR **DATE**

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WHITE - SECURITY ADMINISTRATOR

ADM35 (1/06R) **pidreq**