

INFORMATION MANAGEMENT PASSWORD REQUEST FORM

**PLEASE RETURN COMPLETED FORMS TO IM BOX 159 – PASSWORD ADMINISTRATION
FORM MAY BE FAXED TO 880-3292**

Employee Name <i>Please Print Clearly</i>	Last Name		First Name		MI
Employee's Job Title			Last Name of Administrator		
Employee or Doctor Number		Phone		Pager	
New Employee?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date of Hire:		
Transfer?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Job Change, Old Title:		
Cost Center or Nursing Station			Department:		
Building Name		Room #		Box #	Shift (D or E) Days / Evenings

NOTE: ALL APPLICABLE BOXES MUST BE COMPLETED ABOVE. WE ARE UNABLE TO PROCESS FORMS WITHOUT DEPARTMENT NAMES, SIX-DIGIT COST CENTERS, BUILDING LOCATIONS, AND EMPLOYEE OR DOCTOR NUMBERS.

**PASSWORDS WILL BE ISSUED WITHIN 10 WORKING DAYS.
PLEASE CALL THE HELP DESK, AT X3445, WITH ANY QUESTIONS.**

A. Please Check the Appropriate Action:					
<input type="checkbox"/>	Request for New System Access				
<input type="checkbox"/>	Request to Amend System Access				
	List Systems Currently Available to You:				
<input type="checkbox"/>	Request for Network Password Change	Has Password Been Compromised?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/>	Request for HBOC CHIP Password Change	Has Password Been Compromised?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/>	Remove Access to All Systems, Delete Employee Security Code	If Employee is Leaving CMMC, List Date:			
Does Your Department Have a Novell Network?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Does Your Department Use Windows 95 on Your PC?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do You Need Email Access?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Have You Ever Had Email Access Under Any Other Name? If so, Please List Name:					

B. If This is a Request for New System Access or Amended System Access, Complete the Following:					
List the Name of a Person Who Currently Has the Same Access to the Same Functions That You Will Need					
Print the Name of the Employee:		Security Class(es) If Applicable:			

TO DETERMINE WHO IS THE APPROPRIATE PERSON TO GIVE AUTHORIZATION	
IF YOU ARE:	REQUIRED AUTHORIZATION SIGNATURE:
ADMINISTRATIVE STAFF	YOUR ADMINISTRATOR OR DIRECTOR
MEDICAL STAFF	YOUR DIVISION CHIEF
MEDICAL SUPPORT STAFF	YOUR DIVISION CHIEF

Employee's Signature		Date	
Authorizer's Signature		<i>No Rubber Stamp Signatures Allowed</i>	
Authorizer's Printed Name			
Authorizer's Title		Ext.	
Signature of Pick-Up		Ext.	
Printed Name of Signature Pick-Up		Date	