



**INOVA HEALTH SYSTEM
SYSTEM ACCESS REQUEST FORM**

Request Number: _____

A request/call number is REQUIRED. Please obtain from the Customer Support Line at 703-889-2000
IT will process your request for System Access within 5 to 10 business days after receiving an approved SARF.

User Demographics: To be completed by Resident

Last Name: _____ First Name: _____ MI: _____
 Job Title: **Resident/Fellow** Process Lvl/Dept: **110/924** (xxx/xxx) Facility: **IFH/IFHC/HVI**
 Department: _____ Work Phone: _____ Physician ID #: _____
 Date of Birth: _____ (mm/dd/yy) Gender: _____ (M or F) SS#: _____

Is this request for an Inova Employee?	<input type="checkbox"/> Yes			
	<input type="checkbox"/> No	If No, then please specify:	<input type="checkbox"/> Consultant	Name of Consultant Company: _____
			<input type="checkbox"/> Other	Date Access to be Removed: _____ (mm/dd/yy)

System Access Information: To be completed by GME Staff

Request Type: New User Access Effective Date: _____ Update Access Effective Date: _____
 Transfer Access Effective Date: _____ Deactivate Access Effective Date: _____

System Access Requested:

Please place a check mark in the space(es) for the system access requested.

- | <u>*CLINICAL</u> | <u>*FINANCIAL</u> | <u>*FINANCIAL</u> | <u>OFFICE</u> | <u>REMOTE</u> |
|---|---|--|--|---|
| <input type="checkbox"/> IDX CareCast | <input type="checkbox"/> Lawson - AP, GL, MM | <input type="checkbox"/> HealthQuest (Medipac) | <input type="checkbox"/> Network Access ¹ | <input type="checkbox"/> Citrix |
| <input type="checkbox"/> Cerner | <input type="checkbox"/> Lawson - Payroll, HR | <input type="checkbox"/> Cashier ID | <input type="checkbox"/> E-Mail | <input type="checkbox"/> AS5300 (Dial-In) |
| <input type="checkbox"/> Siemens-Radiology | <input type="checkbox"/> Lawson - Activities | <input type="checkbox"/> Abstracting ID | <input checked="" type="checkbox"/> Internet Access | <input type="checkbox"/> VPN Access |
| <input type="checkbox"/> ImageCast/PACS | <input type="checkbox"/> ANSOS/One-Staff | <input type="checkbox"/> Horizon Business Folder (HBF) | | |
| <input type="checkbox"/> USA Scheduling RMS | <input type="checkbox"/> Full Access | <input type="checkbox"/> InovaPass ¹ | | |
| <input type="checkbox"/> USA Scheduling OR | <input type="checkbox"/> Self Scheduler | <input type="checkbox"/> Manager Access | | |
| <input type="checkbox"/> VISICU/eCareManager | <input type="checkbox"/> Trendstar | <input type="checkbox"/> Timekeeper Access | | |
| <input type="checkbox"/> Picis ED Pulse Check | <input type="checkbox"/> Horizon Business Insight (HBI) | | | |

¹If the user is replacing another user, please indicate the name of user who is being replaced: N/A

If applicable who should access be set up like? N/A

If applicable what is the station ID that the new user will be using: N/A

Please specify other system access requirements & shared drive access requirements below:
N/A

Additional Comments or Explanation of business function that requires this access:

Rotation Start and End Dates: _____

Approval Information:

ALL REQUESTS MUST BE APPROVED BY A MANAGER OR DIRECTOR

I hereby certify that all information contained on this form is true and complete. Falsified statements of facts on this form shall be considered sufficient basis for dismissal.

<u>Maureena Crawford</u> **Manager/Director (Print Name)	_____ Signature (Not Required for eSARF Submission)	_____ Approval Date	<u>703-776-3879</u> Phone #
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<u>Maureena Crawford</u> *Authorized Trainer (Print Name)	_____ Signature	_____ Approval Date	<u>703-776-3879</u> Phone #
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*Clinical and Financial systems may require an additional authorized signature.
 ** Manager/Director name must be filled in to process request electronically.
 Refer to Inovanet for instructions.

Send Completed Form To: Information Technology Security Department
 2990 Telestar Court, 2nd Floor
 Attention: IT Security Analyst
FAX #: 703-205-2189
E-mail: SARF Mailbox