UNITED STATES
NAVAL HOSPITAL OKINAWA, JAPAN

FORM TITLE

CLINICAL INFORMATION SYSTEMS USER ACCESS REQUEST

CHCS: ☐ **AHLTA:** ☐ **Essentris:** ☐ **Synapse:** ☐

Part I - User Information

Name (Last, First, Middle Initial)	Rank	DoD ID #	Rotation Date (MM/DD/YYYY)

Clinic Location:	Duty Phone:	
AUDIOLOGY CLINIC	Cell Phone:	

Have you previously had a USNHO CHCS Account?

Sex: M ◉ **F** ○ | **DoD Email**:

List a person in your Dept that have the same menus you require:

Signing this form constitutes an understanding that you are accepting total responsibility for your clinical information accounts. **You will be held legally responsible for all actions taken under your account**; all actions could be used as evidence in legal cases against you and the hospital. **Remember, this account is for your individual use only** and under no circumstances whatsoever, will it be shared for any reason.

If this account is for a Provider or Nurse they must have their credentials approved at USNH Okinawa Japan before an account is created for them. Please contact the credentialing office in Room 4E506 or call at 646-7918. IDCs must submit Page 13 certification with this request to get their account access processed.

User's Signature:

Part II - Department Head (DH)/Division Officer(DIVO) Verification

DH/DIVO Name:		Duty Phone:	
DoD Email:		Cell Phone:	

TYPE OF ACCESS REQUESTED - Please select from the menus below

Administrative
Clerk

Signature Class
Corpsman

Functional Roles (select all that apply):

None
Admissions
APU Functions
Booking Appointments
Emergency Room Functions
Immunizations
Inpatient Records

☐ **Other:**

I, the undersigned, confirm the rights requested in this form are appropriate to the job the requester is assigned to.
I understand that accounts must be logged into every 30 days, or they will be disabled and deleted.
I understand that access will not be granted until the requester has attended the relevant CIS training.

Department Head Signature: