

# MARSHALL HEALTH INFORMATION SYSTEMS ACCOUNT REQUEST

## SECTION I: APPLICANT INFORMATION

Request Type:    New User Account                  Role/Dept Change		Today's Date:
Name (Last):		Previous Last Name(s):
Name (First):		Middle:
Date of Birth:		Phone:
Current address (Street/PO Box):		
City:	State:	ZIP Code:
Marshall University ID Number (901xxxxxx):		Start Date:
Email address (required for EHR account):		

## SECTION II: POSITION/ROLE INFORMATION

Student: (if Y, complete and skip to next section)	(length of visit): _____
School:	Start Date:                          End Date:
Employer:	if Other (explain):
Department:	
Clinical Provider :	
Clinical Support Role:	
Non Clinical Support Role:	
Other Role:	
Other Role if Not Defined Above:	

## SECTION III: TYPE OF SYSTEM ACCESS REQUESTED

Electronic Health Record - Allscripts:	PM System – Flowcast (Billing/Scheduling)	Library Access:
Sharepoint	Doc Halo Secure Texting	Healthstream
Evercheck	Dragon Dictation	

Justification reason REQUIRED for all non-Marshall Health employees (Please briefly explain):

Badge Access (indicate where):

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Applicant Signature:		Date:
Name (Last):	(First):	
<b>SECTION IV: CLINICAL USER INFORMATION</b>		
Department/Division:	Specialty:	
Building/Room Number:	Office Phone Number:	
Clinic Physical Address (Street/City/St/ZIP):		
Clinic Phone Number:	Clinic Fax Number:	
Primary Printer Location:	Primary Printer/ Print Queue Name:	
Provider's NPI# <span style="color: gray; font-weight: normal;">REQUIRED FOR PROCESSING</span>	Taxonomy Code/Effective Date:	
Provider State License :	Exp. Date:	
Provider DEA Number:	Exp. Date:	
Scheduling Provider:	Billing Areas (include all; or mirror setup of which provider ):	
Patient Visit Types (or mirror setup of...):		
Billing Provider:	Billing Locations (or mirror setup of which provider):	
If Non-billing, list billing provider to bill services under (required for all Residents, PAs, others billing incident to):		
<b>SECTION V: CLINIC SUPPORT STAFF INFORMATION</b>		
State License # :	Exp. Date:	
<b>SECTION VI: MISCELLANEOUS INFORMATION</b>		
Phone ext:	Supervisor:	
<b>AUTHORIZATION SIGNATURE</b>		
Authorized by (Printed Name):		
Title:	Phone:	
Signature:	Date:	

\*\* Please forward to **Jeremy Lloyd** with an attached copy of Driver's License  
 \*\* [lloyd5@marshall.edu](mailto:lloyd5@marshall.edu) Fax: (304) 691-6369