

**IntelliDose (Nursing/Pharmacy/Inquiry Only)**

Electronic Health Record (EHR) Access Request Form  
University of Miami Miller School of Medicine

THIS INFORMATION IS TO BE FURNISHED BY THE REQUESTOR (PLEASE PRINT LEGIBLY)

Please complete ALL sections on ALL pages of this form (Incomplete forms will not be processed)

NEW USER ACCESS       MODIFY USER ACCESS

REQUESTOR'S INFORMATION

LAST NAME	M.I.	FIRST NAME	MEDICAL USER NAME (EMAIL) <b>*REQUIRED*</b>
POSITION TITLE (e.g. Assistant Professor/MD)		EMPLOYEE ID#	TELEPHONE/BEEPER
ORGANIZATION NAME	LOCATION (BLDG/RM) (e.g. Bldg-SCCC/Rm#3023)	DEPARTMENT/DIVISION (e.g. Medicine/Cardiology)	

ROLE/FUNCTIONAL ACCESS REQUIRED

RN       Pharmacy       Nursing and Pharmacy Administration (Reports)

**Inquiry Only** (Functional Roles: Administrative Assistants, Coding, Financial Representatives, etc.)

**Research** (Functional Roles: Investigators and/or Coordinators who are contributing to the scientific development or execution of a protocol)

**Accessing this system for the purpose of research requires that the requestor notify the CIMS department once his/her CITI certification expires.**

**UMCET Analyst**

By signing this access request form I understand that I will receive a unique username and password that is not to be shared and/or made public and will sign off the system before leaving the workstation. I will be using IntelliDose within 3 weeks of the date of my training. **For the sole purpose of research, I understand that I must notify the CIMS department once my CITI certification expires, at which point, access to the IntelliDose system will be revoked. Access will be granted once my CITI certification is renewed.**

Requestor Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**\*IMPORTANT: REFER TO THE STEPS IN THE SECOND PAGE TO PROPERLY SUBMIT THIS FORM.\***

REQUESTOR'S UM SUPERVISOR, AUTHORIZING MANAGER, SPONSOR/LIASON OR ADMINISTRATOR

By signing this access request form, I acknowledge and confirm the above requestor needs access to the EHR in order to perform his/her job functions. I will notify the CIMS department upon this employee's termination and/or transfer to a different position or department where access must be assessed as it relates to their job functions by their new supervisor. **Furthermore, if access is granted for the sole purpose of research, I understand that the employee's CITI certification must first be confirmed as current prior to authorizing access. In addition, I will notify the CIMS department upon this employee's expiration of his/her CITI certification. Access to the system will be granted once the CITI certification has been renewed.**

Requestor's UM Sponsor/Supervisor Printed Name:	Requestor's UM Sponsor/Supervisor Signature:	Date:	Telephone/Ext:
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**DESCRIPTION OF APPLICATION**

IntelliDose is an electronic system that automates chemotherapy order-writing and chemotherapy nursing documentation.

**HIPAA (Privacy & Security of Protected Health Information)**

The University of Miami has developed policies and procedures for the use and disclosure of University patient health information in compliance with applicable state and federal laws, including the **Privacy & Security** standards promulgated under the **Health Insurance Portability and Accountability Act of 1996 (HIPAA)**. By signing this form you hereby agree to comply with HIPAA. If you have any questions concerning our policies and procedures, please contact the Office of Privacy and Security at **305-243-5000**, email us at [hipaaprivacy@med.miami.edu](mailto:hipaaprivacy@med.miami.edu), or visit our site: <http://med.miami.edu/hipaa>.

**SECURITY ADMINISTRATION PROCEDURES**

1. Complete the required information on the EHR Access Request form.
2. Return the completed form(s) to the Clinical Information Management Systems Department. The form can be faxed to 305-243-7355. Training Registration is not complete until the form(s) are received with appropriate signature(s).
3. The completed form will be submitted to the appropriate Departmental Representatives for approval.
4. Username and password will be assigned & sent via email once the request is approved and the training has been completed.

Need HELP? Contact the CIMS Support Desk at 305-243-7339.

Requestor Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**\*IMPORTANT: SIGN ABOVE TO CONFIRM THAT YOU'VE REVIEWED AND UNDERSTOOD THE CONTENTS OF THIS PAGE.\***

**UMCET STAFF ONLY**

Date form received:	Access processed by:	Date request completed:
Username assigned:		Access group assigned:
Date of training:	Trained by:	ARF Status/Comments (i.e. pending info, missing info, etc.):