KRONOS
Access Request Form
University of Miami Miller School of Medicine

DESCRIPTION OF SYSTEM

This application is designed for Managers, Supervisors and Lead Workers to enter employee schedules & edit employee schedules and employee timecards in the Kronos Workforce Central application.

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

- Please complete ALL sections on ALL pages of this form (Incomplete forms will not be processed).
- The applicant must sign the yellow section **(SECTION A)**. The supervisor must sign the green section **(SECTION B)**.

❑ **NEW USER ACCESS** ❑ **MODIFY USER ACCESS** ❑ **REMOVE USER ACCESS**

APPLICANT'S INFORMATION

FIRST NAME	M.I.	LAST NAME	PHONE NUMBER (WITH AREA CODE)

REQUIRED *FIELDS*

C# *REQUIRED* (IF NO C#, MUST INCLUDE DATE OF BIRTH)	DATE OF BIRTH (IF NO C# IS PROVIDED, MUST INCLUDE DATE OF BIRTH)
MEDICAL USER NAME (EMAIL) *REQUIRED*	

POSITION TITLE	ORGANIZATION NAME (e.g., ABLEH, UMH, UMHC, UMMG, OTHER)
LOCATION BUILDING	DEPARTMENT/DIVISION or TAG GROUP #

ROLE/FUNCTIONAL ACCESS REQUIRED

If appropriate for multiple departments, please list departments:

1. _____ _____
2. _____ _____

SECURITY ADMINISTRATION PROCEDURES

1. **Complete the Kronos Access Request Form and fax to: Clinical Enterprise Technologies at 305-243-7355.**
2. **The completed form will be reviewed to meet all requirements and you will be assigned a username and password upon completion of your ULearn Module and signing of access request form. If you need assistance, please contact the CET Support Desk at 305-243-7339.**

APPLICANT'S SIGNATURE

SECTION A

By signing this access request form, I understand and agree to maintain the confidentiality of employee information. Furthermore, 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. In addition, I understand that if I don't access the system for over 3 months, my account will be deactivated.

APPLICANT'S SIGNATURE	APPLICANT'S PRINTED NAME	DATE

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

SECTION B

By signing this access request form, I acknowledge and confirm that the above applicant needs access to the system referred to in this application in order to perform his/her job functions. I will notify the CET 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.

SUPERVISOR'S SIGNATURE	SUPERVISOR'S PRINTED NAME	SUPERVISOR'S PHONE #	DATE