

**Department of Medicine**  
**Patient Information Computer Systems Access Request**

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Division: \_\_\_\_\_

E-mail: \_\_\_\_\_

Phone #: \_\_\_\_\_

JHH LID ID \_\_\_\_\_

PAGER # \_\_\_\_\_

Please circle which systems you need access too:

EBED      TAP      \*Compliance +      Patient Keeper      Other

I have successfully completed Johns Hopkins HIPAA training.

\_\_\_\_\_  
Signature

Supervisor or Division Manager Name:

\_\_\_\_\_  
Print

\_\_\_\_\_  
Signature

\*Please fax forms back at (410)955-0430 attention: Rachel Wood\*