

Frankfort Regional Medical Center

Remote Gateway Access Request

Section 1: User Information (Complete all fields in Section 1)			
Last Name:	First Name:	Middle Initial:	Work Phone:
Name of Physician/Physician Practice:			
Address of Practice:			
City:	State:	Zip:	
User Title/Position:		Name of Office Manager:	
User SSN:		User Date of Birth:	
Will User require access during travel?			
Section 2: User Acknowledgement (Must be signed by requesting user)			
<i>I acknowledge that I have read the Remote Gateway Connection Agreement and I agree to comply with all terms and conditions stated therein.</i>			
User Signature:			Date:
Section 3: Approvals (Must be signed prior to account creation/assignment)			
Office Manager Signature:			Date:
Security Coordinator Signature:			Date:
Section 4: IT&S Use Only			
Access Needed: <input type="checkbox"/> UID <input type="checkbox"/> VPN <input type="checkbox"/> SSL <input type="checkbox"/> Secure ID _Hard Token _Soft Token	Secure ID Card: <input type="checkbox"/> New <input type="checkbox"/> Replacement Reason: _____ <input type="checkbox"/> Transfer Card Serial #: _____	<input type="checkbox"/> Meditech – KYB <input type="checkbox"/> PACS	
UID:	Serial #:	Notified:	
VPN Group:			IT&S:
Section 5: User Receipt			
<i>I acknowledge receipt of a Secure ID hard or soft token, required software, installation instructions and Users Manual. I accept responsibility for the security and confidentiality of these items and the information accessed with their use.</i>			
User Signature:			Date of Receipt:
Date Inactivated/Returned:			By: