Instructions for WebLIMS LabWare Access Request Form

FORMS MUST BE LEGIBLE.

Typed forms preferred but neatly handwritten forms are acceptable. If illegible, the form will be returned, which may cause a delay in the application process.

Only complete the sections below on the form

Section #1.

- For Facility, enter the name of your hospital or physician's office. Add address and county and enter facility license #.
- For Physician/Physician staff access – enter the name of the physician authorizing access. Check Yes or No to indicate if the facility indicated is your primary location.

Section #2.

- Indicate your First Name, Middle Initial, and Last Name.
- Enter user license number, if applicable. License # is not required for staff personnel.
- **Enter the last 4 digits of your SSN**. Digits will be required for verification if you need your network password reset by DOH. Please fill in your **e-mail address.** If you do not have one please provide your direct supervisor's e-mail address. This is very important, as most communications regarding the Bureau of Public Health Labs Web Portal are sent via e-mail.

Section #4 User Acknowledgement Signature

- Multiple locations/users require separate forms. Each form must be signed by the user requesting access AND the supervisor in charge of that facility/unit. Forms not bearing all required signatures will be delayed in being processed.

Section #5 User Type Application - Check the type of user for this application.

- **Physician, Nurse, or staff member check staff under the appropriate designation.**
- Enter Name, License #, Title, Email and Phone number of authorized person. Sign and Date form.

PLEASE FAX OR EMAIL FORMS TO THE FOLLOWING:

FAX NUMBER: **1 (904)-791-1567 ATTN: Jackie Sayers**

EMAIL ADDRESS: DLBPHLLAR@flhealth.gov

Please allow 3 weeks for processing.
Any cancellations of access forms must be done in writing to the fax number or email address above.

NOTE: IF A USER'S ACCOUNT REMAINS INACTIVE FOR 30 DAYS THE USER ACCOUNT WILL BE DELETED AND THE ENTIRE APPLICATION PROCESS MUST BE REPEATED TO REGAIN ACCESS .

Revised 6/2017

Bureau of Public Health Laboratories
Communications Service Request
WebLIMS LabWare Access Request

Fax this page only to:
1 (904) 791-1567
ATTN: Jackie Sayers
***or* email to:**
DLBPHLLAR@flhealth.gov

1. Facility or Physician Information

Name _____

Address
_____

County _____

City _____, Florida Zip _____

Is this your primary location? ◯ Yes ◯ No

License # _____
(Facility / Physician)

2. User Information

Name _____

Title _____

E-mail _____

Phone _____ Ext _____

Last 4 SSN# _____ (Required)

User License # _____
(Physicians, Nurses and DOH Licensed Users only)

3. Date/Period Needed **(DOH USE ONLY)**

From (MM/DD/YYYY) _____

To (MM/DD/YYYY) **INDEFINITE**

DOH USE ONLY. DO NOT COMPLETE

Username _____

4. I acknowledge that remote access is for official Bureau of Public Health Laboratories' business purposes only and that the use of DOH computer and network connections may be monitored at any time to assure compliance with DOH policies. Section 382.026, Florida Statutes, specifically states that any person who, without lawful authority and with the intent to deceive, makes, counterfeits, alters, amends, or mutilates any certificate, record, or report commits a felony of the third degree.

User Signature **(Required)** _____

5. User Type Application: ***Check Only One*** ◯ Physician ◯ Nurse ◯ Physician Staff

As the Physician, Hospital Supervisor or Nurse or Phys. Staff Supervisor, I approve and authorize this request, and retain all responsibilities for records filed under my purview per ch. 382, Florida Statutes.

Signature **(Required)** _____ License # _____
(If applicable)

Printed Name _____ Title _____

E-mail _____ Phone _____ Date _____

6. System Administrator's Acknowledgement **(DOH Use Only. DO NOT COMPLETE)**

I have reviewed this Citrix Access Request. All information on this request is accurate.

_____ _____

Print System Administrator Name | System Administrator Signature | Date

7. Director/Administrator Acknowledgement (DOH Use Only. DO NOT COMPLETE)

I, the Program Office Director and State Registrar authorize DOH IT to enable Citrix access for this user. By completing this form, my office accepts all financial obligations associated with this request.

Print Director/Administrator Name Susanne Crowe, MHA

Director/Administrator Signature _____ Date _____

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