St. Luke's Hospital

Provider IT Access Form Date Sent to IT: _____ Date Completed by IT: _____

Provider Information (Med Staff Office to Complete)

Full Name (first, middle, last): _____

Credentials: _____ Specialty: _____

Practice Name: _____

Primary Office Address: _____ Suite: _____

Primary Office City/State/Zip: _____

Primary Office Phone: _____ Office Fax: _____

Cell Phone: _____ Last 4 SSN: _____

Start Date: _____ End Date (if known): _____

DEA: _____ NPI: _____

License Number: _____

Provider Type: ☐ Physician ☐Resident ☐ Allied Health ☐ Med Student ☐ CNP ☐ Other: _____

Access Information (Med Staff Office to Complete)

Does St. Luke's Hospital employ the physician? ☐ Yes ☐No

Does the physician need a hospital email account? ☐ Yes ☐No

Password/Username Information (IT to Complete)

Network Username: _____ Password: _____

Application Access

Cerner: _____ Mmodal: _____ AzureMFA: _____

Comments

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