Mary Washington Healthcare System Access Request

Instructions:
Complete the form below ensuring you complete all required fields, as indicated by an asterisk (*), for the appropriate request category. (Non-Associates - Physician Office Staff, Students, Credentialed Providers, Non Credentialed Providers, Contractors, Vendors, and Consultants)

Send Completed Form To:

Medical Staff and Medical Office Staff please return the completed form along with a signed Confidentiality and Security Agreement to Physician Liaison Services at physicianhelp@MWHC.com or fax to 540-741-1837.

All others please send your completed form along with a signed Confidentiality and Security Agreement to your Mary Washington Healthcare Business Partner.

Direct any new account questions to your Mary Washington Healthcare Business partner.

NOTE: Account requests may take up to seven calendar days to complete once a signed Confidentiality Agreement and all required information is provided. Delays in providing the required documentation and information will delay the account build.

I GENERAL ACCOUNT INFORMATION

Have you ever had a Mary Washington Healthcare login previously Yes / No. If yes what was the login id if known.

First Name (No Initials) *	**Middle Name** (No Initials) *	**Last Name** *	Suffix (Jr, Sr., III, etc)

Gender*	Nickname (If Desired/Preferred)	**Official Title** *

Build Account Like (Enter Employee Number and name of user in same or similar role)

Employer Company Name *	Employer Main Phone Number (if exists)	Employer Main Fax Number (if exists)

Employer Street Address *	**Employer City** *	**Employer State** *	**Employer Zip Code** *

Individual's Direct Phone Number at Employer *	**Individual's Email Address** * (NO GROUP EMAIL ADDRESSES ACCEPTED)

Employer Supervisor's Full Name *	**Employer Supervisor's Direct Phone Number** *	**Employer Supervisor's Email Address** *

II ADDITIONAL REQUIREMENTS

VENDOR, CONSULTANT or CONTRACTOR

MWHC Company Assigned *	**MWHC Department Assigned** *

MWHC Department *Contact Full Name* *	**MWHC Department Contact Phone Number** *	**Contracted Work Start Date** *	**Contracted Work Stop Date** *	**Contract Expiration Date** *	Individual's Assigned MWHC Telephone Number

☐ Vendor ☐ Consultant ☐ Contractor

PROVIDER (MD, PA, NP)

☐ Credentialed	☐ Non Credentialed	**Specialty***	**NPI***	**License***

MWHC Assigned Provider ID *

TERMS OF USE AND CONFIDENTIALITY AGREEMENT

I acknowledge that the accounts requested for network and systems access are provided to me according to the terms of my employment, partnership, or contract arrangement with Mary Washington Healthcare (MWHC), its companies, or ventures. I understand it is my responsibility to protect these accounts, and access resources only in accordance with the terms in the MWHC Confidentiality and Security Agreement. I agree that this access is granted to me for the performance of official duties only, and will not be used for personal purposes. I understand that my access and activities on any MWHC network or system may be monitored, and my access revoked at any time. I have read, fully understand, signed, and agree to the terms set forth in the MWHC Confidentiality and Security Agreement.

Printed Name *	Signature *	Date