Instructions for Citrix Remote Access 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, funeral establishment, or medical examiner district office. Add address and county and enter facility license #.
- For Practitioner/Practitioner staff access – enter the name of the Practitioner authorizing access.
- Check Yes or No to indicate if the facility indicated is your primary location.
- If you need access to multiple locations, indicate name and license # of the facility. Use another form as needed.

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 **email 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 e-Vitals Electronic Registration System are sent via e-mail.
- If user is from a funeral home, indicate if access to the Electronic Fetal Death Registration System is being requested.

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.**

- **Check Birth Registrar, Funeral Director, Medical Examiner, Practitioner, Tax Collector Supervisor, or if you are a 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: **1-855-698-0671**

EMAIL ADDRESS: vs.qastaff@flhealth.gov

Please allow 1-2 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 60 DAYS THE USER ACCOUNT WILL BE DELETED AND IN ORDER TO REGAIN ACCESS THE ENTIRE APPLICATION PROCESS MUST BE REPEATED.

Bureau of Vital Statistics
Communications Service Request
Citrix Remote Access

Fax this page only to:
1-855-698-0671 ***or*** **email to:**
vs.qastaff@flhealth.gov

1. Facility or Practitioner Information (Required)

Name ____

Address ____

City____________________________, ZIP _____________

County _________________ License # _________________

Is this your primary location? __________ Yes/No

If multiple locations requested, list facility name & license #:

Facility Name	License #
______________________________	_______________
______________________________	_______________
______________________________	_______________
______________________________	_______________
______________________________	_______________
______________________________	_______________
______________________________	_______________

2. User Information (Required)

Name ____

Title ____

Email ____

Phone __________________________ Ext __________

Facility Fax # ___________________________________

Last 4 SSN # __________________ *(Delayed, if omitted)*

User License # _________________________________
(Funeral director / Practitioner Users only)

Death users only:
Indicate if user is requesting access to the Electronic Fetal Death Registration System (EFDRS) __________ Yes / No

3. Date/Period Needed (*DOH Use Only. DO NOT COMPLETE*)

From (MM/DD/YYYY) _____________To INDEFINITE

Username ______________________________________

4. I acknowledge that remote access is for official Bureau of Vital Statistics 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*** _____ Birth Registrar/Admin Staff _____Tax Collector Staff

____ Funeral Director ____ Funeral Staff ____ Medical Examiner ____ ME Staff ____Practitioner ____ Practitioner Staff

As the FDIC, Medical Examiner, Practitioner, Hospital Supervisor or Tax Collector Supervisor, I approve and authorize this request, and retain all responsibilities for records filed under my purview per Chapter 382, F.S.

Signature of Person Authorizing Access (Required) _____________________________License # ________________
(If applicable)

Printed Name ____ Title ______________________________

Email ____ 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 Ken Jones

Director/Administrator Signature ____ Date ________________