



ST. LUKE'S

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: \_\_\_\_\_ Secure Email: \_\_\_\_\_

Provider Type:  Physician  Resident  Allied Health  Med Student  CNP  Other: \_\_\_\_\_

**Access Information (Med Staff Office to Complete)**

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

Does the physician need a hospital email account?  Yes  No

Previous DR Number?  Yes  No \_\_\_\_\_

**Password/Username Information (IT to Complete)**

Network Username: \_\_\_\_\_ Password: \_\_\_\_\_

**Application Access**

Cerner: \_\_\_\_\_ Mmodal: \_\_\_\_\_

Surgery: \_\_\_\_\_ Cardiovascular: \_\_\_\_\_

**Comments**

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