

<p align="center">UCLA MEDICAL CENTER SEND FORM TO: Department of Medicine 32-139 CHS. M/C: 173617</p>	<p align="center">ACCESS REQUEST FORM- PHYSICIAN</p>	MCCS USE ONLY
USER ID:		
PLEASE TYPE (or print legibly) REQUIRED INFORMATION BELOW.		
IF YOU NEED HELP TO COMPLETE THE FORM, PLEASE CONTACT GITI ZARENIA @ EXT. 55799		
(1) LEGAL NAME (Last/First/Initial) [REQUIRED]	(2) Pager number [REQUIRED]	(3) TELEPHONE (Work) [REQUIRED] ()
(4) ORGANIZATION AND MAILING ADDRESS [REQUIRED] (Department/Room no./Building or Street Address/City, State & Zip)		
(5) MOTHER'S MAIDEN NAME OR IDENTIFYING WORD [REQUIRED]	(6) EMPLOYEE ID:	(9) 4-DIGIT TITLE CODE
UNAUTHORIZED COMPUTER USE: Unauthorized use of Medical Enterprise computer equipment and or data could result in University disciplinary action (up to and including termination), and may constitute grounds for either civil action(for restitution) or criminal prosecution. I HAVE READ AND UNDERSTOOD THE ABOVE STATEMENT: <div style="text-align: right;"> _____ Applicant Signature [REQUIRED] Date[REQUIRED] </div>		
(12) AUTHORIZER [REQUIRED] _____ Signature / Print Name Date	MSO Signature [REQUIRED] _____ Signature / Print Name Date	

MANDATORY explanation for Request: