TRAUMA REGISTRY
USER NAME AND PASSWORD REQUEST

CHECK APPROPRIATE BOX :

New Hire -

Change ____________________________

DELETE (effective)______________________

STATUS :

Trauma Coordinator

Trauma Registrar

Contract Professional

Hospital Administrator

Other Staff

SECTION 1. CONTACT INFORMATION (Even if you are deleting a user please provide this information)

PLEASE PRINT/or Type

FACILITY NAME____

Name____ TITLE:______________________________

(Last, First, Middle Initial)

Phone #____

Mailing Address____

City____ State________________________ Zip Code_________________

EMAIL ADDRESS: ____

SUPERVISOR INFORMATION

Contact Name____ TITLE:______________________________

(Last, First, Middle Initial)

Contact Address_________________________________ City___________________ State____________ Zip Code__________

Phone Number________________________

Email Address:____

Signature:____

Your signature authorizes the NM DOH/ERD/EMSB/Trauma Program to set up/remove access to facility trauma registry.

SECTION 2: System Needs

- Hospital admin Role
  - Access to all trauma records for that facility only
  - Can set up facility users
- Hospital Registrar Role
  - Has access to all trauma records for that facility
  - Can view users (cannot set up users)
- Data Submission and Report Pickup only
  - Used by other facilities that may need to submit data and/or view reports

SECTION 3. NM DOH/EMSB/TRAUMA PROGRAM USE ONLY

USER NAME:____

PASSWORD:____

EFFECTIVE DATE:____

Signature Authorized Person: ____

SECTION 3. Add/Remove User to these email lists

TRW TNCF	TASSC TSFA	Additional ____________________________