New User Form

To be completed by User requesting QHN access

The information below is required to be completed by each User requesting access to the Quality Health Network (QHN) System. Users will be notified by phone, with their secured access information when their account has been established in the QHN System. Once the form is completed by typing into the below fields, it may be electronically signed and emailed to: Support@qualityhealthnetwork.org or printed, signed and faxed to QHN at: 970.248.0043.

User Information

Full Name: *First* *Last* *M.I.* **Date:**

Professional Suffix: Select from dropdown menu, if applicable **Other Title:**

Preferred Contact Phone: **Cell Phone:**

Preferred Contact Email Address:*

**Please note: This email address is used for the reset password function in the QHN system.*

Please list the work location(s) where you will access the QHN system below:

Security Information (Used to verify your identify for Password changes, etc.)

Last 4 Digits of Your Social Security Number: ☐☐☐☐

Month and Day of Birth: **Month:** ☐☐ **Day:** ☐☐

User Acknowledgement and Signature

It is your responsibility as a User of the QHN System to ensure your password is kept confidential. Please **INITIAL** next to each statement and sign at the bottom.

☐ I will change my password and set my security questions during the initial login process to the QHN System. In so doing, I understand that no one else, including Quality Health Network, will know my password or my responses to my security questions.

☐ I will not share my password with anyone or ask another user for their password.

☐ I will not log anyone else on to the QHN System using my password.

☐ I understand that upon accessing the QHN System for the first time, I will be asked to accept additional policies above and beyond those outlined in this document.

☐ I understand that any inappropriate access to the QHN System may result in the imposition of sanctions against me, my supervisors and/or my organization that could include loss of use of the QHN System, notice to licensing authorities, and/or civil or criminal penalties.

☐ I understand and agree to be bound by all the above statements.

Signature: _____ **Date:** _____

Printed Name: _____

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