QHN User Application

QUALITY HEALTH NETWORK — Improving care through shared technology

A QHN **User Application Form** must be completed for each User. User will receive their secured access information by phone. Completed form may be emailed to: Support@qualityhealthnetwork.org or faxed to QHN at: 970.248.0043.

To be Completed by Authorized Organizational Contact

Practice | Organization | Facility Information

Practice | Organization | Facility Name: **Department:**

User Information

Full Name: **Specialty:**

First *Last* *M.I.*

Preferred email contact address: **Professional Suffix / Title:**
Select from dropdown menu, if applicable

NPI #: **License #:**

If using QHN Single Sign On please note their user name (for your EHR system) below:

Training by QHN representative is requested (fee may apply).
Yes: No:

User Access Requested (at least one option must be selected)

- **Demographics Only:** This User will not access clinical information, Patient Demographics view only.
- **Organization Results:** User will access results/demographics associated with your practice patients only.
- **Full QHN System Access**: User will access all patient results/demographics from all QHN sources.
  One- time fee may apply ($50). I understand fee will be applied to our organization's monthly invoice.
- **QHN Direct**: User needs Direct Email account (Tip Sheet on Designating Direct Delegates).
- **Other:**

Organizational Contact Signature

By signing below, I certify that User has completed the required **HIPAA and Confidentiality** training and all information contained herein is accurate. I affirm that all access, by my organization, to the QHN system(s) shall be in compliance with the Electronic Commerce Agreement between our organization and QHN, applicable law, QHN's Governing Policies and that any inappropriate use or access to the QHN system may result in the imposition of sanctions by QHN, against me and/or my organization that could include loss of use of the QHN System, notice to licensing authorities, and/or civil or criminal penalties. **View QHN's Governing Policies.** I have certified the identity of the individual noted above by viewing and verifying two legal forms of identification.

Designated Organization Contact Signature (required) **Printed Name** **Email address** **Date**

To be Completed by User

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 QHN User, to ensure your password is kept confidential. Your signature below acknowledges that you understand and agree to be bound by the following statements: 1) To not share your password with anyone or ask another user for their password. **2)** To not login anyone else to the QHN System using your password. **3)** Upon accessing the QHN System accept the additional policies and conditions noted on the login screen.

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.

User Signature (required) **Printed Name** **Date**

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