FlexScanMD Access Form

By filling out this form and signing below, I acknowledge that SOM IT has fully and duly informed me of the potential for misuse and abuse of roles and permissions pertaining to the authorization of one or multiple clinics. I will be responsible for educating the employee of the consequences of misuse and abuse of roles and permissions. I will also absolve SOM IT of all responsibility resulting from abuse and misuse of roles and permissions pertaining to the authorization of one or multiple clinics.

Please write the information of the employee whom you are sponsoring below. If the employee works at multiple clinics and you would like this employee to have this authorization to one or multiple clinics, please specify below. All fields are required.

***Please note that it may take up to 2 business days for this request to be processed.*

Name:_____ Employee ID:_____ Phone:_____

Email:_____ Athena Username:_____

Job Title:_____

Current Role(s):_____

What type of access will you need for **FlexScanMD?** (Select Access Type)

☐ Sales & Inventory ☐ Sales ☐ Super User

What department(s) will you need access to? _____

Please list if there are more departments:_____

Please list if there are more departments:_____

Date access needs to start:_____ Date access needs to end:_____

Supervisor Signature

Printed Name:_____ Signature: _____ Date: _____

NON-UTRGV Employees

- Copy of government issued photo ID required
- Sponsorship by Senior Director of Clinical Operations or Senior Director of Clinical Administration required

Senior Director of Clinical Operations

Printed Name:_____ Signature:_____ Date:_____

Senior Director of Clinical Administration

Printed Name:_____ Signature:_____ Date:_____