



Arkansas EMS Registry
ED Hospital Hub™ User Access Request

User Information	
Name:	User Type: <input type="checkbox"/> HH User <input type="checkbox"/> HH Local Admin
Hospital:	
Address:	
Phone Number:	Email:

Hospital Trauma Medical Director and/or Hospital Administrator Information*	
Name:	Title
Phone Number	Email:
Signature	

*will be used to verify hospital's authorization for access

My signature indicates my understanding of, and, agreement with the following:

- *That information entered into and contained in the **ED Hospital Hub™** is confidential.*
- *That I will use the information in the **ED Hospital Hub™** only for the purpose for which it is intended and as required by my job.*
- *That the unauthorized disclosure of personal, identifiable information is strictly prohibited.*
- *I will not share any information that is accessible through the **ED Hospital Hub™** without proper authorization.*
- *I will not share my **ED Hospital Hub™** user ID and password with any other users, authorized or unauthorized.*
- *At the end of each **ED Hospital Hub™** session, I will log out of the **ED Hospital Hub™** application and close my Internet browser.*
- *That the data collected is authorized under the provisions of the Arkansas Rules and Regulations for Trauma Systems, Promulgated under the Authority of Act 559, 1993.*

Signature:	Date:
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Approved <input type="checkbox"/>	Denied <input type="checkbox"/>	Verified by:	Date:
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