



Arkansas Trauma Registry

User Access Request

User Information*	
Name:	<input type="checkbox"/> Registrar <input type="checkbox"/> Trauma Program Manager <input type="checkbox"/> Trauma Coordinator
Hospital:	
Address:	
Phone Number:	Email:

*Please Print

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

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

Signature	
<p>My signature indicates my understanding of and agreement with the following:</p> <ul style="list-style-type: none"> • <i>That information entered into and contained in the Arkansas Trauma Registry is confidential.</i> • <i>That I will use the information in the Arkansas Trauma Registry only for the purpose for which it is intended and as required by my job.</i> • <i>That the unauthorized disclosure of personal, identifiable information is strictly prohibited.</i> • <i>I will not share any information that is accessible through the Arkansas Trauma Registry without proper authorization.</i> • <i>I will not share my Arkansas Trauma Registry user ID and password with any other users, authorized or unauthorized.</i> • <i>At the end of each Arkansas Trauma Registry session, I will log out of the Arkansas Trauma Registry application and close my Internet browser.</i> • <i>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.</i> 	
Signature:	Date:

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