THE UNIVERSITY OF CHICAGO MEDICINE
AT THE FOREFRONT OF MEDICINE®

REQUEST FOR EMPLOYEE ACCESS TO CARELINK FOR AN EXTERNAL ORGANIZATION

To facilitate review of this request, please provide complete, accurate information.

I. Type of Request

☐ New Site Employee List

☐ Additional Employee(s) for Existing Site

II. Medical Practice/Facility Information

Medical Practice/Facility Name _____

Street _____ Suite Number _____ City _____ State _____ Zip Code _____

Site Contact Full Name: _____

Email: _____ Telephone Number: _____

Site Contact User Type: Provider (Indicate Type – MD, NP, RN, etc): _____ ☐ Clinical Staff ☐ Non-Clinical Staff ☐ HIM Requestor ☐ Auditor

VP of Network Development Approval: ☐ Approved ☐ Not Approved

_____

VP of Network Development Signature Date

III. Employee Information (All Fields Are Required For Identity Verification)

Name	DOB MM/DD/YY	User Type	Provider Type	Email	Telephone

For Official Use Only

Processed By: _____ Date Processed: _____