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| **ACCESS REQUEST**  National Fatality Review Case Reporting System | | | |
| Name | Title | | |
|  |  | | |
| Team | Access Requested | | |
|  | CDR  FIMR | | |
| Street Address | | | |
|  | | | |
| City | | State | ZIP Code |
|  | |  |  |
| Email Address\* | | Phone Number | |
|  | |  | |

\*An email address is required to set up an account.

Please return this form, along with the signed confidentiality statement, to:

|  |  |
| --- | --- |
| Primary Contact | Back-up Contact |
| Catheryn Morateck  **Email:** cmorateck@childrenswi.org  **Phone:** 414-337-4568  **Mailing address:**  Children’s Health Alliance of Wisconsin – Children’s Hospital of Wisconsin  6737 W. Washington St, Suite 4300  West Allis, WI 53214 | Emily Morian-Lozano  **Email:** [emily.morianlozano@dhs.wisconsin.gov](mailto:emily.morianlozano@dhs.wisconsin.gov)  **Fax:** 608-267-3824  **Phone:** 608-867-4700  **Mailing address:**  Wisconsin Department of Health Services  1 W. Wilson St., Rm. 233  Madison, WI 53703 |
|  |  |
| **For Office Use Only** | |
| Permission levels assigned: | |

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| --- | --- | --- |
| **CONFIDENTIALITY STATEMENT FOR STATE AND LOCAL USERS**  National Fatality Review Case Reporting System | | |
| By signing this Agreement, I agree to the following when I access any and all components of the National Fatality Review Case Reporting System  1. I will comply with all laws, regulations, policies, and procedures as set by the State of Wisconsin.  2. I will safeguard the confidentiality of all confidential information to which I have access. I will not carelessly handle confidential information. I will not in any way divulge, copy, release, sell, loan, review, alter, or destroy any confidential information except as within the scope of my duties.  3. I will only access confidential information for which I have a need to know and I will use that information only as needed to perform my duties.  4. I will safeguard and will not disclose my user name and password unless authorized by the state administrator of the reporting system. I understand that my user name and password allows me to access confidential information for my team on the National Fatality Review Case Reporting System. I understand that the State administrator may revoke my access to the data system if my responsibilities change.  5. I will promptly report activities by any individual or entity that I suspect may compromise the availability, integrity, security, or privacy of confidential information.  6. I understand that the ownership in any confidential information referred to in this Agreement is defined by State statute.  7. I understand that violating applicable laws and regulations may lead to other legal penalties imposed by the judicial system. | | |
| **SIGNATURE** – User | | Date Signed |
|  | |  |
| Print Name | Team | |
|  |  | |