|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **DEPARTMENT OF HEALTH SERVICES**  Division of Care and Treatment Services  F-03146 (05/2023) | |  | | | | | **STATE OF WISCONSIN**  Wisconsin Resource Center |
| **FACILITY REQUEST FOR DHS CONNECT VIEWER ACCESS** | | | | | | | |
| **Add access to DHS Connect Viewer** | | | | **Remove access to DHS Connect Viewer** | | | |
| **EMPLOYEE INFORMATION:** To be completed by requestor. | | | | | | | |
| DOC Facility | | | | | | | |
|  | | | | | | | |
| First Name | MI | | Last Name | | | | |
|  |  | |  | | | | |
| DHS Connect Position | | | | | | | |
| Navigator Read Only: | | | | | | | |
| Name of Employee with Similar Role (First, MI, Last) | | | | | | | |
|  | | | | | | | |
| Employee Email Address | | | | | Employee ID | | |
|  | | | | |  | | |
| IAM Username | | | | | | | |
|  | | | | | | | |
| **SIGNATURES** | | | | | | | |
| **SIGNATURE –** Requestor | | | | | | Date Signed | |
|  | | | | | |  | |
| **SIGNATURE –** Approver | | | | | | Date Signed | |
|  | | | | | |  | |
| Send completed form to [DHSWRCDHSConnectAccess@dhs.wisconsin.gov](mailto:DHSWRCDHSConnectAccess@dhs.wisconsin.gov) | | | | | | | |
| **The following to be completed by WRC personnel only:** | | | | | | | |
|  | | | | | |  | |
| Approved at WRC  Yes  No | | | | | |  | |
| **SIGNATURE –** Director of Nursing or Designee | | | | | | Date Signed | |
|  | | | | | |  | |
|  | | | | | | | |

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| --- | --- | --- |
| **DOC WORKFLOW ROUTING** | | |
| **Staff Type** | **Requestor** | **Approver** |
| Psychology | PSU Supervisor | PSU Approver for Max, Med., or Min. Facilities |
| Nursing/Primary Care/Psychiatry | Health Services Manager | Nurse Coordinator |
| Central Medical Records | Health Information Supervisor | Health Information Supervisor |