

Agency Non-Provider User Activation Request Form



Person Requesting Activation

Name: _____ Title: _____

Agency: _____ E-Mail: _____

System Level User Information

CCNY Use Only:

Name	Email Address	Role Requested:	Reason Requested:	Date Access Sent	Date Assigned
		Agency Admin Agency Admin- Financial			
		Agency Admin Agency Admin- Financial			
		Agency Admin Agency Admin- Financial			
		Agency Admin Agency Admin- Financial			
		Agency Admin Agency Admin- Financial			
		Agency Admin Agency Admin- Financial			

Approval of Provider Change Request

The above request cannot be processed until this section is complete.

(Signature)

Name (Print)

(Date)

(Title)

Verification of Provider Change Request

I verify that the above-described provider(s) have been activated in Fidelity EHR according to the above instructions.

CCNY(Signature)

CCNY Name (Print)

(Date)

* This form can be sent to CCNY via email (<mailto:dnichy@ccnyinc.org>) or fax (716)855-0004 attn: Doug.