OnCore Access Request

First Name: _____ Last Name: _____

Employed by (check one) WVURC ☐ WVUM ☐ WVU ☐ Other _____ (*specify*)

Work Email: _____

Work Phone: _____ Ext: _____

Fax: _____ Pager: _____

Department: _____ Title: _____

Credentials: (check one): MD ☐ PhD ☐ DO ☐ PharmD ☐ RN ☐ Other ____

College/Division: _____ PO Box: _____

Work Address: _____

City: _____ State: _____ Zip: _____

Clinical Trials Role (check one):

PI ☐ Co-Inv. ☐ Study Coordinator ☐ Data Manager ☐ Regulatory ☐ Pharmacy ☐

Accounting ☐ Other- (specify reason for access): _____

I agree to abide by Federal and Institutional HIPPA and HITEC guidelines and related activities concerning data and patient information.

Signature: _____ Date: _____

Authorized Requestor Name: _____ Phone: _____

Authorized Requestor Signature: _____ Date: _____

Authorized Requestor must notify the OnCore Administrator, via email at OnCoreAdmin@hsc.wvu.edu, when the employee leaves this role so their access can be deactivated.

For Office Use Only
Role: _____
Management Group(s): _____
Date Training Completed: _____