



UniMEDS USER ACCESS FORM

APPLICANT DETAILS			
<input type="checkbox"/> HASA Staff <input type="checkbox"/> Others _____			
Name		NRIC	
Staff No		MMC No.	
C&P No.		Duration	Start Date:
NSR No.			End Date:
Department		Unit	
Phone No.		Email Address	
ACCOUNT APPLICATION			
Applied For (Please Check)			
<input type="checkbox"/> Hospital Information System (UniMEDS)			
<input type="checkbox"/> Specimen Management System (SMS)			
<input type="checkbox"/> Others: _____			
USER CATEGORY (FILL BY AUTHORIZED PERSONNEL)			
UniMEDS		SMS	
<input type="checkbox"/> Admin <input type="checkbox"/> Clerk <input type="checkbox"/> Nurse <input type="checkbox"/> Research Assistance <input type="checkbox"/> Medical Assistance <input type="checkbox"/> MLT <input type="checkbox"/> Record <input type="checkbox"/> MSW <input type="checkbox"/> Store <input type="checkbox"/> Financial	<input type="checkbox"/> Optometrist <input type="checkbox"/> Science Officer <input type="checkbox"/> Pharmacist <input type="checkbox"/> Physiotherapist <input type="checkbox"/> Radiographer <input type="checkbox"/> Dietitian <input type="checkbox"/> Doctor <input type="checkbox"/> Consultant <input type="checkbox"/> Clinical Specialist <input type="checkbox"/> Medical Officer	<input type="checkbox"/> Pathologist <input type="checkbox"/> Science Officer <input type="checkbox"/> MLT <input type="checkbox"/> Nurse	Other System: (Please State)
HEAD OF DEPARTMENT			
Verified By:		Signature	Date
DIRECTOR/ DEPUTY DIRECTOR (CLINICAL) HASA UITM			
Verified By:		Signature	Date
OFFICE USE (IT DEPARTMENT)			
Authorized By		Signature	Date
Username		Password	<input type="checkbox"/> Training Date: