

## INTERNET ACCESS REQUEST FORM

Facility Type: \_\_\_\_\_

**A copy of the facility's state license must accompany this application.**

<b>1. Facility Information</b>	
Facility Name:	
License Number:	
Contact Person:	
Title of Contact Person:	
Phone number and extension of the contact person:	
Fax number of the contact person:	
E-mail address of the contact person:	
<b>2. List of Individuals Authorized to Submit Reports</b>	
List the names and titles of the individuals authorized to submit reports. A separate account and user ID will be established for each person submitting reports to the Agency. (please print)	
Name of Authorized Person	Title
a.	
b.	
c.	
d.	
<b>3. Signatures of Authorized Individuals</b>	
By accessing this system, I am agreeing to follow the Agency for Health Care Administration's policies regarding acceptable use and protection of confidential health care information. By submitting electronic reports, I am affirming that the information contained in the reports are true, correct, and can be relied upon by the recipient pursuant to Florida law.	
a.	Date:
b.	Date:
c.	Date:
d.	Date:

Mail To: FDAU  
 Agency for Health Care Administration  
 2727 Mahan Drive, MS # 47  
 Tallahassee, Florida 32308