

Instructions for Citrix Access Forms

- **FORMS MUST BE LEGIBLE.**
Typed forms preferred but neatly handwritten forms are acceptable. If not legible, the form will be returned delaying the application process.
- **Complete Section #1.**
For the Office Acronym, leave this item blank.
For Site Name, indicate your hospital's name.
- **Complete Section #3.**
Indicate your First Name, Middle Initial, and Last Name.
Leave user name BLANK.
Enter the last 4 digits of your SSN as they will be required for verification if you need your network password reset by DOH. Please fill in your email address. If you do not have one please provide your direct supervisor's email address. This is very important, as most communications regarding the e-Vitals Electronic Birth Registration System are sent via email.
- **Complete Section #7.**
Circle the Function Group role you are requesting.
- **Complete Section #12.**
Print Name, Sign and date
- **Complete Section # 14.**
Have your supervisor print their name, sign, and date

PLEASE FAX OR EMAIL FORMS TO THE FOLLOWING:

FAX NUMBER: 1-866-624-8321

EMAIL ADDRESS: vsgastaff@doh.state.fl.us

Please allow 2 – 3 weeks to be processed.

Any cancellations of access forms must be done in writing either by email or fax to:

FAX NUMBER: 1-866-624-8321

EMAIL ADDRESS: vsgastaff@doh.state.fl.us

Please note:

IF A USER'S ACCOUNT REMAINS INACTIVE FOR 90 DAYS THE USER ACCOUNT WILL BE DELETED AND IN ORDER TO REGAIN ACCESS THE ENTIRE APPLICATION PROCESS MUST BE REPEATED



**Department of Health
Communications Service
Request
Remote Access (Citrix-Internal)**

*Note: See Instructions and fax to
1-866-624-8321*

1. Site/Bureau Information Office Acronym: Site Name: Address 1: Address 2: City/State/Zip: 10 Digit Phone:	2. Billing Address Site Name: Address 1: Address 2: City/State/Zip: <input type="checkbox"/> Same as Site Information	3. Requester Information Name: Title: Username: Email Address: Phone: LAST 4 SSN: Fax:
4. Justification for Access e-Vitals Electronic Birth Registration – Governance #252		5. Date/Period Needed From (MM/DD/YYYY): To (MM/DD/YYYY): Indefinite
6. Applications Needed _____ _____		8. Network Shares Needed (\\server\shared_directory\folder) _____ _____
7. Function Grp: Hosp Admin Birth Registrar (CIRCLE ONE)		
9. Cost Number of months requested: _____ Monthly charge (\$): \$ _____ Total Charge: \$ _____		10. Billing Information EO: SAMAS ORG Code: OCA: Version: FID:
11. User's Acknowledgement <i>I acknowledge that remote access is for official state business purposes only and that the use of DOH computer and network connections may be monitored at any time to assure compliance with DOH policies.</i>		12. Print User Name: _____ User Signature: _____ Date: _____
13. Supervisor's Acknowledgement <i>I have reviewed with the user, pertinent DOH policies, including but not limited to those related to overtime and compensatory time, security and computer use, and telecommuting.</i>		14. Print Supervisor Name: _____ Supervisor Signature: _____ Date: _____
15. System Administrator's Acknowledgement <i>I have reviewed this Citrix Access Request. All information on this request is accurate and all required signatures are valid.</i>		16. Print System Administrator Name: _____ System Administrator Signature: _____ Date: _____
17. Director/Administrator's Acknowledgement <i>I, the CMS/CHD Director, Program Office Director, or Administrative Director authorize DOH IT to enable Citrix access for this user. By completing this form, my office accepts all financial obligations associated with this request.</i>		18. Print Director/Administrator Name: _____ Director/Administrator Signature: _____ Date: _____
For Office Use Only		
Incomplete: _____ Approved: _____ Rejected: _____		
Comments: _____		
19. Security Administration Signature		20. Date