
 **Access Request Form**

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## *\*\*IMPORTANT\*\* All fields are required*

First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  M.I: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Title/Credentials: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Blazer ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ UABMC ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Department: **\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Must be either “**blazerid”@uab.edu* *or* *“uabmc ID”@uabmc.edu**.*

Work Phone: **\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Campus Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date OnCore training completed: \_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_

 mm dd yyyy

Please list a user with the functionality you are requesting (If applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Role(s) (select all that apply)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | BSM Administration Role |  | CCTS Staff |  | Principal Investigator |
|  | BSM User |  | Center Administrator |  | Protocol Information Coord. |
|  | CCTS Administrator |  | Co-Principal Investigator |  | Regulatory Manager |
|  | CCTS CRSP |  | Data Manager |  | Study Coordinator |
|  | CCTS Management |  | Financial Manager |  | Other – Please specify |
|  | CCTS Regulatory Manager |  | Management Reporting |  |  |
|  | CCTS SPAN |  | Multi-Role Manager |  |  |

**Management Group (select all that apply)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Anesthesiology |  | ID-HIV |  | PEDS: Neo |
|  | BSM |  | ID-STI |  | PEDS: Nephrology |
|  | Breast Imaging |  | Interventional Radiology |  | PEDS: Neurology |
|  | CHRU |  | Laboratory Medicine |  | PEDS: Pulmonary |
|  | CRUBIO |  | Memory Disorders |  | Pediatric Surgery |
|  | CRUCRSP |  | Met Lab |  | Phase I - MC |
|  | CRUNUR |  | Molecular Imaging, Therapeutics, and Advanced Medical Imaging Research |  | Physical Medicine and Rehabilitation(PM&R) |
|  | Cardiology |  | Movement Disorder |  | Plastic Surgery |
|  | Cardiothoracic Surgery |  | Multiple Sclerosis |  | Preventive Med |
|  | Clinical Nutrition |  | Nephrology CTG |  | Psychiatry |
|  | CRE |  | Nephrology Transplant |  | Psychology - HIV |
|  | Dermatology - Clinical Research |  | Neuro-Muscular |  | Psychology - Pain |
|  | Dermatology - Grants |  | Neuropathology |  | Psychology - Therapy |
|  | Diagnostic Radiology |  | Neuropsychology |  | Public Health - Addiction |
|  | Emergency Medicine |  | Neurosurgery |  | Pulmonology |
|  | Endocrinology |  | OB/GYN-MFM |  | RadOnc |
|  | Epidemiology |  | Optometry |  | Rheumatology |
|  | Epilepsy |  | Oral & Maxillofacial Surgery (OMFS) |  | Sleep/Wake Disorders |
|  | GI/HEP |  | Orthopedic Surgery |  | Stroke |
|  | Gastrointestinal Surgery |  | Otolaryngology(OTOL) |  | Transplantation Surgery |
|  | Gen Internal Med |  | PEDS: Cardiology |  | URO/GYN |
|  | Genetics |  | PEDS: Critical Care |  | Urology |
|  | Gerontology |  | PEDS: Hem/Onc |  | Vascular & Endovascular Surgery |
|  | Hem/Onc |  | PEDS: ID |  | Other – Please specify |
|  | ID-CTG |  |  |  |  |
|  |  |  |  |  |  |

# Applicant- Print Name Signature Date Signed

Applicant’s Manager -Print Name Signature (required) Date Signed

## *Please return form to OnCore Administration via email at* OnCore@uabmc.edu