

Physician Link Account Setup

Check one:

- New Token**
 Replacement Token
 Modify Account Setup

Please complete form with all signatures affixed and fax to (415) 600-7072

NOTE: YOU MUST COMPLETELY FILL OUT THIS FORM. INFORMATION IN THE BOX BELOW IS MANDATORY ESPECIALLY A VALID EMAIL ADDRESS AS ALL CORRESPONDENCE IS DONE VIA EMAIL. PLEASE PRINT LEGIBLY.

Name: _____			
	Last	First	Middle Initial
Address: _____		Please answer the following for identification purposes: Last 4 Digits of Social Security Number: _____	
City: _____	State: _____	Zip Code: _____	Last 4 Digits of Home Phone: _____
Email Address: _____		Work Phone: _____	
Medical Records Campus - for Pickup of Token			
<input type="checkbox"/> California <input type="checkbox"/> Davies <input type="checkbox"/> Pacific <input type="checkbox"/> St. Luke's			

What application(s) do you need to access through Physician Link? *(Check all that apply)*

- PCIS Online *(physicians with a PCIS account already established)*
 Radiology PACS/Imaging *(physicians only)*
 Ophthalmology PACS/Imaging *(EPS physicians only)*
 Surgery Scheduling System *(additional information required below)*
 IBEX *(Emergency Department physicians only)*
 Heartlab Pacific & Heartlab St. Luke's *(physicians only)*
 Physician Direct *(physicians with patients at St. Luke's only)*
 My Patients, Phone Directory, On Call *(additional information required below)*

Surgery Scheduling System Setup

Please list the names of all surgeons associated with this user account. For each surgeon listed below, the user will have access to their scheduling information.

1. _____ 3. _____
 2. _____ 4. _____

My Patients, Phone Directory, On Call Setup

Please list the names of all physicians associated with this user account. For each physician listed below, the user will have access to complete patient demographics for that physician. *(Check one)*

- All Physicians in** _____ **Practice Group***
Fill in Practice Group Name
 List Names of All Physicians in Group: _____
- Individual Physician***
 Physician Name: _____

**Authorizing physician signing as approver for this form must either be a member of practice group or the individual physician named above.*

