

	Knowledge Management and Information Technology Service	Page No.	Page 1 of 1
		Revision No.	0
	Service Request Form		Effectivity:

Reference Code: _____

1) Date of Request (mm/dd/yyyy): ____/____/____

Privacy Notice: All information collected through this form shall be used for the purpose of (1) database of TB care providers for reporting TB Human Resource-related indicators, (2) basis for processing of ITIS account, and (3) contacting for patient referrals and informing of NTP activities. Your contact details will be accessible by all ITIS users while personal information such as Birthday and PRC Number shall be accessible only by the approval party. If you wish to revoke your registration, you may send us an email via ntp.helpdesk@doh.gov.ph. All information collected will remain secure and confidential within authorized personnel only.

2) Name of Contact Person: _____		
_____	_____	_____
Last Name First Name Middle Name		
3) Office: _____		
4) Address: _____		
5) Landline: _____	6) Fax No. _____	7) Mobile No. _____
8) DESCRIPTION OF REQUEST: (Please clearly write down the details of the request.)		

REQUEST FOR NEW ACCOUNT
(RO, PHO/CHO or Facility Validator must register the personnel in Directory prior submission of this form to KMITS. If facility is not available in ITIS, submit first the request for addition of facility. Form is available in ITIS Downloads.)

Creation of ITIS User Account for: (Please check) <input type="checkbox"/> WEB <input type="checkbox"/> DESKTOP (applicable for DOTS facility only)	Type of Service/s: (Please check) <input type="checkbox"/> Office <input type="checkbox"/> DOTS <input type="checkbox"/> IDOTS <input type="checkbox"/> PMDT - TC/STC <input type="checkbox"/> Referring Facility <input type="checkbox"/> Notifying Facility (MTBN)	<input type="checkbox"/> QA Center <input type="checkbox"/> TB Microscopy Laboratory <input type="checkbox"/> RTDL <input type="checkbox"/> DST/TB Culture Laboratory <input type="checkbox"/> Warehouse <input type="checkbox"/> Others (please specify): _____
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*Title:	<input type="checkbox"/> Dr. <input type="checkbox"/> Mr. <input type="checkbox"/> Ms. <input type="checkbox"/> Others _____		
*Last Name:	_____		
*First Name:	_____		
*Middle Name:	_____		
Name Extension:	_____	Maiden Name:	_____
*PRC License No.: (write N/A if this is not applicable for the personnel)			
*Birthdate:	_____		
*Email Address:	_____		
*Sex:	<input type="checkbox"/> Male <input type="checkbox"/> Female		
*Mobile Number:	_____	Landline Number:	_____
*Profession:	_____		
*Main Health Facility:	_____		
*Designation:	<input type="checkbox"/> Director/Health Office Head/Facility Head/Laboratory Head <input type="checkbox"/> Health Officer <input type="checkbox"/> TB Medical Coordinator <input type="checkbox"/> TB Nurse Coordinator <input type="checkbox"/> TB Medical Technologist Coordinator	<input type="checkbox"/> Supply Officer <input type="checkbox"/> Physician <input type="checkbox"/> Nurse <input type="checkbox"/> Medical Technologist <input type="checkbox"/> Nurse/Laboratory Aide <input type="checkbox"/> Others _____	
Position:	_____		
*Employment Status:	<input type="checkbox"/> Permanent (Regular) <input type="checkbox"/> Temporary <input type="checkbox"/> Contractual (Project-Based) <input type="checkbox"/> Casual (Job Order) <input type="checkbox"/> Volunteer		
*User Level:	<input type="checkbox"/> Viewer <input type="checkbox"/> Encoder <input type="checkbox"/> Validator <input type="checkbox"/> Notification Officer (Project/LGU hired) <input type="checkbox"/> Private Physician Notifier <input type="checkbox"/> Private Facility Notifier		

Where did you hear of this registration? or How were you informed of this registration? or Who assisted you in your registration?		Remarks:
<input type="checkbox"/> Regional Health Office	<input type="checkbox"/> PBSP	
<input type="checkbox"/> Local Government Unit	<input type="checkbox"/> URC	
<input type="checkbox"/> PhilCAT	<input type="checkbox"/> Kalinga Health	
<input type="checkbox"/> PTSI	<input type="checkbox"/> Medical Societies	
<input type="checkbox"/> fhi360	<input type="checkbox"/> Others _____	

*means required field

9) APPROVED BY: _____	
Name & Signature of Head of Office	

Position	

(For Knowledge Management and Information Technology Service only)

10) Date Received (mm/dd/yyyy): ____/____/____	11) Time Received (hh:mm) : ____AM ____PM
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12) **ACTIONS TAKEN:** (Use separate sheet if necessary)

DATE (a)	TIME (b)	ACTION TAKEN (c)	ACTION OFFICER (d)	SIGNATURE (e)

13. NOTED BY: _____	14. _____	15. _____
Name and Signature of Supervisor	Position	Date Signed