	Knowledge Management and Information Technology Service	Page No.	Page 1 of 1
		Revision No.	0
	Service Request Form	Effectivity:	May 02, 2014

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. 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 ACCOUNT UPDATE

(RO, PHO/CHO or Facility Validator must update the details of personnel in Directory prior submission of this form to KMITS.)

Account update for:
(Please check)
☐ **WEB**
☐ **DESKTOP** (applicable for DOTS facility only)

Account information update on: (Please check)
☐ **Access Level** (refers to access rights to information based on location)
☐ **User Level** (refers to set of restrictions and permissions as to roles and system capabilities)
☐ **Default Station** (Area of Assignment – please provide location)
☐ **E-mail Address**
☐ **Contact Number**
☐ **Change of Surname**
☐ **Account Deactivation/Reactivation**
☐ **Addition of Other Affiliated Facilities of Private Physician (TBMN)**
☐ **Inactivation of Other Affiliated Facilities of Private Physician (TBMN)**

Name (First Name, M.I., Last Name) / **Username**	**From** (Current)	**To** (Update)	**E-mail Address**	**Contact Number**

Name (First Name, M.I., Last Name) / **Username**	**Complete Name of Facility**	**Reason for Deactivation/Reactivation**

Applicable for TB Mandatory Account (Private Physician)

Note: *Private Physician can do self-tagging of their affiliated facility in their account as well as to remove the tagged facility as needed.*

Name (First Name, M.I., Last Name) / **Username**	**Other Affiliated Facility/s to tag** (Complete Facility Name)	**Complete Address**

Name (First Name, M.I., Last Name) / **Username**	**Facility to untag** (Complete Facility Name)	**Reason for untagging**

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

_____
Position

(For Knowledge Management and Information Technology Service only)

10) Date Received (mm/dd/yyyy): ____/____/_____ 11) Time Received (hh:mm) ____:____ ☐AM ☐PM

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