PACS
(PICTURE ARCHIVING AND COMMUNICATIONS SYSTEM)
PRIVATE CLINICIAN ACCOUNT REQUEST FORM

If you are unclear about any fields below, call the Service Desk at 1-888-316-7446 or 306-337-0600.
The Service Desk will complete the request within five business days from receiving the request.
Return to: Fax Number: 306-781-8480 or Email: servicedesk@ehealthsask.ca

For Private Clinicians and their clinical staff that require access to the provincial PACS (Picture Archiving and Communications System).

End User Information

Type of request (check one): ☐ New User ☐ Change in User Type ☐ Remove

Environment: Production

Date Access Required: (MM/DD/YY) ______

User's FIRST name LAST name: ______

Email Address: ______ Work Phone #: ______

Work Place Information

Private Practice Name: ______

Private Practice Location: ______

PACS Access Required (select only one)

☐ Point of Care Provider with VPN Access: This is the **DEFAULT** access provided to Private Practices.

☐ Point of Care Provider (iExport) with VPN Access: This must be reviewed by the Medical Imaging Business Analysts.

ALL PACS Users MUST SIGN this Joint Services / Access Policy Confirmation

I acknowledge I have access to the following. (Please confirm by placing a checkmark in the appropriate boxes):

☐ PACS Joint Services / Access Policy.
☐ Preparing Your Medical Practice for HIPA and PIPEDA.
☐ eHealth Security Policy.

AVAILABLE AT: https://www.ehealthsask.ca/services/PACS/Pages/Register-Pacs-Account.aspx

I acknowledge that I understand that I am legally bound by, and agree to comply with, the PACS Joint Services/ Access Policy.

Name (print): ______ Date Signed: ______ (MM/DD/YY)

Signature: ______

Approval Section

Licensed Practitioner (required)

I acknowledge that the User is permitted access to the selected services. **I acknowledge that the User has read the PACS Joint Services / Access Policy and understands their responsibilities and the appropriate use of PACS as described in the Joint Services / Access Policy as well as their obligations under HIPA.** I further acknowledge that I understand my obligations under HIPA.

Name (print): ______ Date Approved: ______ (MM/DD/YY)

Signature: ______

Please Select Your Licensure Type: ______ Only Licensed Practitioner types currently authorized to access PACS are displayed.