**Virginia Vital Events and Screening Tracking System**

VISITS Early Intervention Provider User Access Request Form

**NAME:** Last First Middle

**E-Mail**:  **User ID:** **Phone#:**

(**REQUIRED-** users that do not provide email address will not be approved for VVESTS/VISITS access.)

**EI Facility Name:**

**Address: City State Zip Code**

(Access will be associated with this address/facility ONLY)

**Working Title**: **Date:**

**Optional: Notary ID #:**  **Notary Expiration Date:**

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| --- | --- | --- |
|  | Role Name | Description of Job Function |
|  | BASIC\_LOGIN | This role need be assigned to all users of the application. |
|  | PART-C\_HEARING | This role is used by Part-C Early Intervention/Infant & Toddler Connection to receive referral information from the Virginia Department of Health Early Hearing Detection Intervention Program (VEHDIP) and to report enrollment status on infants and children referred with a diagnosed hearing loss. |
|  | PART-C\_ADMIN\_HEARING | This role is used by Part-C Early Intervention/Infant & Toddler Connection Administrators and Managers with view only access to conduct surveillance reports on their own system(s). |

**The user agrees to keep the access information like logon-id and password to the Virginia Vital Events and Screening Tracking System confidential. Early Intervention Part-C Providers will receive an e-mail notification about infants and children reported to VDH with a diagnosed hearing loss. EI Providers will access VISITS to receive referral information and report enrollment information to VDH through the VISITS reporting system.**

**SIGNATURES**

Employee/Contractor: Date:

**Supervisors will notify VDH of the termination of an employee by faxing this form to (804) 864-7721 with the below information completed. There-by terminating access to Virginia Vital Events and Screening Tracking System.**

Please terminate access of the above user:

**Notification Date:** **Last Date of Access:**

**MANAGEMENT APPROVAL:**

Supervisor/Manager/Program Director

Print Name: Last First Middle

Title: Phone #: Email:

Signature: Date:

**VDH APPROVAL:**

Division of Child and Family Health: Date:

For Program Questions please call 866-493-1090 Email; [va\_ehdi@vdh.virginia.gov](mailto:va_ehdi@vdh.virginia.gov)

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| VDH Application Help Desk Contact Information: | |
| Phone Number | 804-864-7200 and select option 2 |
| FAX Number | 804-864-7771 |
| Email | [oim\_webappshelp@vdh.virginia.gov](mailto:oim_webappshelp@vdh.virginia.gov) |