Health Services Executive

Primary Care Reimbursement Service

Special Drug Request User Registration Form

Before completing this form please read text below and notes on page three:

- (1) All fields are mandatory unless otherwise stated.
- (2) Please ensure forms are completed correctly in black ink and returned to PCRS.
- (3) The most frequent issues with these forms submitted to PCRS are incorrect completion of the Authorisation Section, illegible entries and missing entries.
- (4) Authorisation of access **must be** performed by the Centres CEO/Delegated person.



Primary Care Reimbursement Service Special Drug Request User Registration Form v1

Information and Data Protection Notice

- 1. Please read the notes on page three of this document before completing this form. All fields are mandatory unless otherwise stated.
- 2. Please use BLOCK CAPITALS and complete all sections. Forms which cannot be processed will be returned to sender by post.
- 3. **Data Protection Notice:** Personal data collected by the HSE is used for the purpose of providing a health service. It is required, stored, processed and disclosed to other bodies in accordance with the laws relating to proper treatment of personal data.

Part 1: Applicant Details																															
Forename												Surname																			
Department														Position																	
Employee No.												Phone No.																			
Office address (see note one)																															
<u> </u>																															
Email Address																															
Username																															
(existing users only)																	-														
Part 2: Role																															
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Please select the access required									Hospital Consultant																						
			HSE-Medicines Management Programme (MMP))															
		PCRS Staff														<u> </u>															
Part 3: Centre																															
Please enter the	nam	e o	f th	е Н	osp	ital	whe	ere y	ou :	req	uire	app	rov	al to	aco	cess	the	Sp	ecia	1 D	rug	Rec	ques	st sy	ste	m			1		
Hospital Name																															
			_		4.					<u> </u>																					
Part 4: User Declaration																															
I understand that details of usernames and passwords must be kept securely and according to the standards which apply to systems access. I am fully aware of data protection issues and my responsibilities regarding the correct use and access of client data.														A	Applicant Signature																
	Part 5: Authorisation																														
with access wh															CEO	O/Delegate Signature															
																						<u>I</u>	$\begin{array}{c ccccccccccccccccccccccccccccccccccc$								
Please scan and IT Operations, P					_		_				_												-	_					ccep	oted	•

Ref Number:

Applicants User ID:

OFFICIAL USE ONLY

Date:

Health Services Executive

Primary Care Reimbursement Service

Special Drug Request – User Registration Form

Notes on this User Registration Request Form:

- 1. Only fully completed request forms will be processed. All fields are mandatory unless otherwise stated. Incomplete forms will be returned to sender by post. Please note that if the "Office Address" is not provided, forms cannot be returned and no further action can be taken by PCRS.
- 2. Authorisation Section: Authorised signatory grades for the purpose of this form are at minimum:
 - a. Hospital CEO
 - b. General Manager
- 3. Certain temporary staff may not have employee numbers. In these cases "Not Available" may be inserted.
- **4.** Completed and signed forms should be scanned, attached and emailed to the Primary Care Reimbursement Service at cert.info@hse.ie. Alternatively, they can be posted to IT Operations, PCRS, Exit 5 M50, North Road, Finglas, Dublin 11. **Forms will not be accepted by fax**.
- 5. Only the single point of contact with PCRS should complete this form.