



MINISTRY OF HEALTH
PHARMACY INFORMATION SYSTEM (PhIS) AND
CLINIC PHARMACY SYSTEM (CPS)



USER ID REQUEST FORM

A. USER INFORMATION

Type of Request:	<input type="checkbox"/> New <input type="checkbox"/> Re-activation <input type="checkbox"/> Reset password <input type="checkbox"/> Change Department/Location/Discipline		
Name:			
ID No:			
Designation:			
	<input type="checkbox"/> Permanent	<input type="checkbox"/> Houseman/Student	<input type="checkbox"/> Temporary
Department:			
Location:	1. 2. 3.	4. 5. 6.	
Contact No:			
Email Address:			

*For prescriber only

Prescriber Type:	<input type="checkbox"/> Resident	<input type="checkbox"/> Visiting	<input type="checkbox"/> Part-time
Discipline:			
Prescriber Category:	<input type="checkbox"/> Consultant/Specialist	<input type="checkbox"/> Medical Officer	<input type="checkbox"/> Others
Registration No:			
Qualification:			
Joint Date:			
Validity (for contract & houseman)			

B. HEAD OF DEPARTMENT ENDORSEMENT

Name:	
Designation:	
Date:	

C. ADMINISTRATOR

Login Name:	Created/Updated by:
	Date:

D. USER ACKNOWLEDGEMENT

I hereby understand and agree to the term set forth in Pharmacy Information System and Clinic Pharmacy System (PhIS-CPS) Guideline and I shall not share my user ID. If I were found to misuse the user ID, disciplinary action shall be taken on me.
Name:
Designation/Stamp:
Date: