



**Form #: DM-F029.1**  
**Title: EDC User Access Request Form**  
**Effective Date: 28-Feb-2014**

Please send the completed form to 410-527-0724 (fax) or sitesupport@h2oclinical.com

**Sponsor: Ferring International Pharmascience Center US, Inc.**

**Protocol Number: Mesalamine 000175**

**User Requiring Access:** \_\_\_\_\_ **Date:** \_\_\_\_\_ DD-MMM-YYYY

First Name:		Middle Initials:	Last Name:
User's Phone #:		User's Email:	
<input type="checkbox"/> Site Personnel	Site #:	Site Name:	
<input type="checkbox"/> CRA <input type="checkbox"/> Other: _____	Company Name:		

**Roles and Access:**

Application	Access and Roles (Check one only)
<input checked="" type="checkbox"/> Oracle inForm	<input type="checkbox"/> Site Coordinator <input type="checkbox"/> Investigator <input type="checkbox"/> CRA/Monitor <input type="checkbox"/> Data Manager <input type="checkbox"/> Read-Only (Clinician/Biometrics/Sponsor)
<b>Other</b>	<b>Details</b>
<input type="checkbox"/> Access Change	<input type="checkbox"/> Role(s) to Remove:
	<input type="checkbox"/> Role(s) to Add:
<input type="checkbox"/> Account Termination	Username to Terminate:

**Training Information:**

Did the User Complete EDC Training? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
If Yes, Date Training Complete: _____ (DD-MMM-YYYY)
Trained by: <input type="checkbox"/> Webinar <input type="checkbox"/> CRA <input type="checkbox"/> Other:

**Requestor Contact Information:**

Print Name	Title	Signature/Date Signed (DD-MMM-YYYY)
Phone #:	Email Address:	

**FOR H<sup>2</sup>O USE ONLY**

Sent Username and Password to:     User     Requestor     Other: \_\_\_\_\_

Sent by:

Print Name	Title	Signature/Date Signed (DD-MMM-YYYY)