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

USER ID REQUEST FORM

A. USER INFORMATION

Type of Request:	□ New □ Re-activation □ Terminate □ Reset password □ Change Department/Location/Discipline	
Name:		
ID No:		
Designation:		
	□ Permanent □ Houseman/Student □ Temporary	
Department:		
Location:	1. 2. 3.	4. 5. 6.
Contact No:		
Email Address:		

*For prescriber only

Prescriber Type:	□ Resident □ Visiting □ Part-time
Discipline:	
Prescriber Category:	□ Consultant/Specialist □ Medical Officer □ 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: