



**Service Request Form**

**Reference Code:** \_\_\_\_\_

1) Date of Request (mm/dd/yyyy): \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Privacy Notice:** All information collected through this form shall be used for the purpose of (1) database of TB care providers for reporting TB Human Resource-related indicators, (2) basis for processing of ITIS account, and (3) contacting for patient referrals and informing of NTP activities. Your contact details will be accessible by all ITIS users. If you wish to revoke your registration, you may send us an email via ntp.helpdesk@doh.gov.ph. All information collected will remain secure and confidential within authorized personnel only.

2) Name of Contact Person: \_\_\_\_\_  
Last Name First Name Middle Name

3) Office: \_\_\_\_\_

4) Address: \_\_\_\_\_

5) Landline: \_\_\_\_\_

6) Fax No. \_\_\_\_\_

7) Mobile No. \_\_\_\_\_

8) **DESCRIPTION OF REQUEST:** (Please clearly write down the details of the request.)

**REQUEST FOR ACCOUNT UPDATE**

(RO, PHO/CHO or Facility Validator must update the details of personnel in Directory prior submission of this form to KMITS.)

<p><b>Account update for:</b> (Please check)</p> <p><input type="checkbox"/> <b>WEB</b></p> <p><input type="checkbox"/> <b>DESKTOP</b> (applicable for DOTS facility only)</p>	<p><b>Account information update on: (Please check)</b></p> <p><input type="checkbox"/> <b>Access Level</b> (refers to access rights to information based on location)</p> <p><input type="checkbox"/> <b>User Level</b> (refers to set of restrictions and permissions as to roles and system capabilities)</p> <p><input type="checkbox"/> <b>Default Station</b> (Area of Assignment – please provide location)</p> <p><input type="checkbox"/> <b>E-mail Address</b></p> <p><input type="checkbox"/> <b>Contact Number</b></p> <p><input type="checkbox"/> <b>Change of Surname</b></p> <p><input type="checkbox"/> <b>Account Deactivation/Reactivation</b></p> <p><input type="checkbox"/> <b>Addition of Other Affiliated Facilities of Private Physician for MTBN</b></p> <p><input type="checkbox"/> <b>Deactivation of Other Affiliated Facilities of Private Physician for MTBN</b></p>
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Name (First Name, M.I., Last Name) / Username	From (Current)	To (Update)	E-mail Address	Contact Number

Name (First Name, M.I., Last Name) / Username	Complete Name of Facility	Reason for Deactivation/Reactivation

*For MTBN only – Affiliated Facility of Private Physician*

Note: Private Physician can do self-tagging of their affiliated facility in their account as well as to remove the tagged facility as needed.

Name (First Name, M.I., Last Name) / Username	Other Affiliated Facility (s) to tag (Complete Facility Name)	Complete Address

Name (First Name, M.I., Last Name) / Username	Facility (s) to untag (Complete Facility Name)	Reason for untagging

9) **APPROVED BY:** \_\_\_\_\_  
Name & Signature of Head of Office Date Signed

\_\_\_\_\_ Position

**(For Knowledge Management and Information Technology Service only)**

10) Date Received (mm/dd/yyyy): \_\_\_\_ / \_\_\_\_ / \_\_\_\_ 11) Time Received (hh:mm) \_\_\_\_ : \_\_\_\_  AM  PM

12) **ACTIONS TAKEN:** (Use separate sheet if necessary)

DATE (a)	TIME (b)	ACTION TAKEN (c)	ACTION OFFICER (d)	SIGNATURE (e)

13. NOTED BY: \_\_\_\_\_ 14. \_\_\_\_\_ 15. \_\_\_\_\_  
Name and Signature of Supervisor Position Date Signed