



Bureau of Health Statistics and Registries
HD01591MP 03/20

Medical Professional User Account Request for PA's Electronic Death Registration System

This form is to be completed to request a user account in PA's Electronic Death Registration System (EDRS).

Requester's Information - Please Print or Type		
1. Requester's First Name, Middle Initial and Last Name		
2. Requester's Email Address (provide a unique work email address for requester, not the general facility or personal email address)		
3. Requester's Facility Name		
4. Facility Street Address (Line 1)		5. Facility Street Address (Line 2)
6. Facility City	7. Facility County	8. Facility Zip Code
9. Facility/Office/Unit Phone Number	10. Facility/Office/Unit Manager Name	11. Facility /Office/Unit Manager Email
12. I complete reports of death at additional facilities in Pennsylvania. Yes No		
13. If #12 is yes, list the additional facilities and addresses where death reports are completed. (attach additional sheets if necessary)		
14. Professional Title a. Authorized Individual Signing the Report of Death MD DO CRNP PA-C Other Specify b. Administrative Support Data Entry/Office Support Facility Account Manager Pronouncer		15. Medical Professionals must provide a valid Pennsylvania License.
Requester's Training Needs		
16. Select one of the following to indicate training needs. I have had training or will receive training from someone at my facility. I need training from the Bureau of Health Statistics and Registries. I plan to become familiar with EDRS using the online training resources at www.doh.pa.gov/edrs .		
Acknowledgment of Responsibilities		
My signature below attests that I am the individual named above and the information I provided on this form is true and correct to the best of my knowledge. I understand and shall adhere to the PA's EDRS User Agreement and Confidentiality Policy . If I checked one of the boxes in #14a above, my signature also indicates I accept that each time an electronic signature is affixed using the unique credentials assigned to me it shall be presumed to be my signature, and the burden of proof for repudiation of this electronic signature shall be on me as the custodian of my unique credentials.		
17. Signature		18. Date
Licensed Healthcare Facility Approval		
I approve that this requestor is authorized to enter information into EDRS on behalf of the facilities listed above		
19. Authorized Representative's Signature	20. Title	21. Date
This completed form may be faxed to 717.265.8383 or scanned and sent via email attachment to RA-DHEDRSUserAcct@pa.gov.		