MMR User Enrollment

Medical Examiner, Physician, and Designated Staff

→→→ Instructions:
1. Provide one type of request (New, Change, Delete) per form.
2. Provide all of the requested information.
3. The physician and each designated staff must sign the application.

☐ **NEW (Add participants)**	☐ **CHANGE (Indicate information to be changed.)**
☐ **DELETE (Suspend all participant rights)**	**Effective Date** _________________
First Notification E-mail Address (required):	
Second Notification E-mail Address (optional):	

(Type or Print)	*(First)*	*(Middle)*	*(Last)*
Physician, ME:			
License Number:			Request Participant ID: ☐ Yes ☐ No
E-mail Address:			Phone Number:
Clinic/Office/Hospital:			Address:
I authorize the following staff access to the MMR system to enter cause and manner of death information on my behalf. I understand that my name will be entered as the individual who provided cause of death information.			
Signature:			Date:

DESIGNATED STAFF

(Type or Print) *(First)*	*(Middle Initial)*	*(Last)*
Name:		
E-mail Address:		Phone Number:
By signing this application I acknowledge that sharing my password or logging into MMR with any participant ID other than my own is a breach of system security and may result in the suspension of my system privileges.		
Signature:		Date:

(Type or Print) *(First)*	*(Middle Initial)*	*(Last)*
Name:		
E-mail Address:		Phone Number:
By signing this application I acknowledge that sharing my password or logging into MMR with any participant ID other than my own is a breach of system security and may result in the suspension of my system privileges.		
Signature:		Date:

(Type or Print) *(First)*	*(Middle Initial)*	*(Last)*
Name:		
E-mail Address:		Phone Number:
By signing this application I acknowledge that sharing my password or logging into MMR with any participant ID other than my own is a breach of system security and may result in the suspension of my system privileges.		
Signature:		Date:

Please retain a copy for your records. Return Form by FAX: 651-201-5740 or by Mail:

Minnesota Department of Health
Office of the State Registrar
P.O. Box 64882
St. Paul, MN 55164-0882

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