



**ICE HEALTH SERVICE CORPS (IHSC)
ACCOUNT REQUEST FORM FOR MEDPAR ACCESS**

REQUESTOR'S INFORMATION

Last Name: _____ First Name _____ Middle Initial: _____
**Work Ph. #: _____ **Work Email Address: _____
Job Title: _____ ** Will be displayed on all MedPAR documents.

REQUESTOR'S ORGANIZATION'S INFORMATION

Organization Name: _____
Detention Facility: _____
(i.e., Port Isabel Detention Center, CBP-OFO Port of Entry Facility, or Border Patrol Station)
Physical Address: _____
City: _____ State: _____ Zip Code: _____ Main Phone #: _____

REQUESTOR'S SUPERVISOR'S INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____
Phone Number: _____ Email Address: _____
Job Title: _____

MEDPAR TERMS AND CONDITIONS

The MedPAR system is deemed Federal Property and owned by IHSC. The MedPAR system training video must be completed to gain access to MedPAR. IHSC authorizes you to use the MedPAR system solely to enter payment authorization requests and track their status. You are not authorized to make the information available on any web site or otherwise reproduce, distribute, copy, store, use or sell the information for any reason without the express written consent of IHSC.

You may NOT distribute your username and password to other individuals for them to gain access to MedPAR. Any access or use that is inconsistent with these terms is unauthorized and strictly prohibited. Violators will be prosecuted. By signing below, I understand and agree to these terms and conditions.

MedPAR System Training Video: Non-IHSC CBP and HSI Date Completed: _____

Requestor's Signature: _____

Requestor's Supervisor Signature: _____

IHSC INTERNAL USE ONLY

Information Verified and Correct: Yes No Verified By: _____

Account Approved: Yes No Approved By: _____

eHR Support Initials Verifying Account Creation: _____ Date Created: _____

**Failure to clearly complete all required fields will result in your MedPAR account request being denied.*