



State of Louisiana

Department of Health and Hospitals
Genetic Diseases Program

Newborn Heel Stick Screening

REGISTRATION FORM FOR USING THE SECURED REMOTE VIEWER

I, _____ am hereby requesting authorization to use the
(signature)
Secured Remote Viewer (SRV) for only receiving newborn screening results of patients to whom I provide medical care.

PLEASE PRINT THE INFORMATION BELOW

1. Full Name: **(NO INITIALS)**

2. Email Address: **(THIS IS REQUIRED)**

3. Full Name of Hospital, Clinic or Health Unit: **(NO ABBREVIATIONS)**

4. Address: Street, Suite Number, City, State and Zip Code

Street

City State Zip Code

5. Telephone number: (_____) _____
Area Code Telephone

Fax number: (_____) _____

6. Return the completed form to Belinda Kassel by fax at 504-219-4452 or via email at Belinda.Kassel@la.gov.

Once your registration form is received an email will be sent inviting you to join the system.