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| Department of Public Health  1380 Howard Street  San Francisco, CA 94103 | **Avatar Account Request Form** | |
| **Date of Request:** |  |

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Last Name: | |  | | | | | First: |  | | MI: |  |
| Job Title: |  | | | | | Email: | |  | | | |
| Office Phone: | | |  | | Office Cell: | | |  | | | |
| New Account | | | | Reactivation/Update – Enter existing Avatar Username: | | | | |  | | |
| Adding Program – If adding a program, please include a separate page naming your current program/s. | | | | | | | | | | | |

**Agency Information:**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Agency/Program Name: | | |  | | | | | |
| Street Address: | |  | | | | City: |  | |
| Zip Code: |  | | | Agency Phone: |  | | Agency Fax: |  |

**Role Information:** *Please check any of the following that apply to your program/agency and your job functions.*

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Mental Health Program | | Substance Use Program – SUD System Code(s): | | |  | |
| Adult/Older Adult (AOA) | | Child, Youth, Family (CYF) | Clinical | | | Clerical/Admin |
| Residential | | Supervisor/Manager/Director | Avatar Scheduling Calendar | | | |
| Like Account (Please provide name of Avatar user whose role is *identical*): | | | |  | | |
| Special Programs: | BHAC  FCMH  FMP  ERMS (AB3632)  MAA Billing | | | | | |

**Co-Signers:** *Please list the full names of up to two eligible, active Avatar users to be co-signers (include a separate page for more).*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 1: |  | | 2: |  | |
| *Or check one:* | | I am a LPHA and therefore do not require a co-signer. | | | I will not be doing clinical work. |

**Training***: If training was conducted on-site, include the* ***Avatar Training Post-Test & Course Evaluation*** *form instead.*

|  |  |  |  |
| --- | --- | --- | --- |
| Requested Training |  | Training Date: |  |

**Required Signatures:** *Please note that incomplete or unreadable forms will not be processed.*

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Employee Signature: |  | | | | Date: |  |
| Supervisor Name (please print): | | |  | Phone: | |  |
| Supervisor Email (please print): | | |  | | | |
| Supervisor Signature: | |  | | | Date: |  |

**Completed forms can be emailed to** [**avataraccounts@sfdph.org**](mailto:avataraccounts@sfdph.org) **or faxed to 415-252-3008.**