



COUNTY OF LOS ANGELES • DEPARTMENT OF PUBLIC HEALTH
PUBLIC HEALTH INFORMATION SYSTEMS
CHOI SYSTEM ACCESS REQUEST



***PLEASE EMAIL COMPLETED FORM TO
 itservice@ph.lacounty.gov***

REQUESTOR INFORMATION

*First Name: _____ *Last Name _____ *E-mail Address _____
 *Agency Name: _____ *Work Phone: _____
 Street: _____ City: _____ Zip: _____ Floor: _____ Rm: _____

REQUEST DETAILS

User Account:

Add New User Delete User Update Existing User Re-enable Existing User

*Access Level Required

- | | |
|---|---|
| <input type="checkbox"/> Agency Administrator | <input type="checkbox"/> Sub-Agency Administrator |
| <input type="checkbox"/> Agency User | <input type="checkbox"/> Sub-Agency User |

Additional Information (if needed):

SIGNATURES

 *Agency User (Print Name)

 *Agency User Signature

 Date

 *Agency Supervisor (Print Name)

 *Agency Supervisor Signature

 Date

 *CHOI Program Approver (Print Name)

 *CHOI Program Approver Signature

 Date