



Indiana State Department of Health

IBRS, IDRS AND IFDRS Confidentiality & User Agreement

As required by Indiana Code 16-37-1 the Indiana State Department of Health has implemented the Indiana Birth Registration System (IBRS) and Indiana Death Registration System (IDRS). The Indiana Fetal Death Registration System (IFDRS) will be implemented by January 2011, as required by Indiana Code 16-37-3. This form is to be used to register all Users, including Administrative Staff, to allow access to these systems.

On page two (2) you will be asked to indicate what role you play in the processing of the record. Most users will have only one role in the death certificate process. An example of multiple roles is a physician who is also the county coroner. The user would need to complete a section on page 2 for each role. If you are a Funeral Director with more than one funeral home location, each location must be listed in this Agreement because each location will be entered into the IDRS.

***Please note – Funeral Directors, each of your funeral home locations will be assigned a different PIN but your Username and Password are the same.**

Send completed form to: **Indiana State Department of Health**
ATTN: Vital Records or **Fax to 317-233-5956**
2 North Meridian Street
Indianapolis, IN 46204

By signing this form, the User acknowledges the conditions under which access to the IBRS, IDRS and IFDRS is granted, and agrees to be held to these conditions:

- All Users shall safeguard their user ID, password and PIN number, if applicable, and maintain system confidentiality.
- All Users shall periodically change their password and a change is REQUIRED every 365 days.
- Users shall notify the Indiana State Department of Health of any changes to this information

Type of account: new user modify account access, If modify Current User ID _____

Check the system(s) you need access to: Indiana Birth Registration System
 Indiana Death Registration System
 Indiana Fetal Death Registration System

Please Print Legal Name of Individual Requesting Access to the System Signature of Requesting User

State issued Operator License (Driver's License) or State ID number of User: _____

State Which Issued the Operator License _____ Date of Birth (month, day, year): _____

Indiana Professional Licensing number: _____ Term Expires: ____/____/_____
(if applicable)

As these systems utilize an electronic signature, this information is used to verify the identity of those requesting access to protect the integrity of the systems.

Email Address of User _____

MUST BE SUBMITTED BY DECEMBER 1, 2010

IBRS, IDRS and IFDRS Facility Location Information

*Please copy and use additional sheets as necessary.

Name of User _____

In order to ensure we received all the submitted pages, please let us know how many different facility locations you are providing:
_____.

1
Facility/Location Name: _____
Indiana License number of facility (if applicable): _____ Expires (month, day, year): _____
Address (number and street): _____
County: _____ City: _____ State: _____
ZIP: _____ Telephone number: _____
Office Manager's Name (used to verify identification of callers for password resets): _____
Office Manager's Signature: _____
E-mail: _____ <i>(List the address where YOU want to receive notification that a record is waiting in the system, if different than the email provided on page 1.)</i>
cc E-mail: _____ <i>(This address should be of the person whom you want to receive, in addition to you, e-mail notification of when a record is waiting in the system. You may select up to 3 cc E-mail addresses. You may choose to leave this blank)</i>
What role will you play in completing the record as this location? Check all that apply:
Birth User Type: <input type="checkbox"/> Certifier <input type="checkbox"/> Administrative Staff
Death User Type: <input type="checkbox"/> Physician <input type="checkbox"/> Coroner <input type="checkbox"/> Deputy Coroner
<input type="checkbox"/> Health Officer <input type="checkbox"/> Funeral Director <input type="checkbox"/> Administrative Staff
2
Facility/Location Name: _____
Indiana License number of facility (if applicable): _____ Expires (month, day, year): _____
Address (number and street): _____
County: _____ City: _____ State: _____
ZIP: _____ Telephone number: _____
Office Manager's Name (used to verify identification of callers for password resets): _____
Office Manager's Signature: _____
E-mail: _____ <i>(List the address where YOU want to receive notification that a record is waiting in the system, if different than the email provided on page 1.)</i>
cc E-mail: _____ <i>(This address should be of the person whom you want to receive, in addition to you, e-mail notification of when a record is waiting in the system. You may select up to 3 E-mail addresses. You may choose to leave this blank)</i>
What role will you play in completing the record at this location? Check all that apply:
Birth User Type: <input type="checkbox"/> Certifier <input type="checkbox"/> Administrative Staff
Death User Type: <input type="checkbox"/> Physician <input type="checkbox"/> Coroner <input type="checkbox"/> Deputy Coroner
<input type="checkbox"/> Health Officer <input type="checkbox"/> Funeral Director <input type="checkbox"/> Administrative Staff

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If you have questions about completing this User Agreement, please call the Help Desk at (317) 233-7989.