Reset Form

Maryland Institute for Emergency Medical Services Systems

Healthcare Facility Access to eMEDS® Reports
Request for Password

To obtain access to eMEDS® Reports, this entire form must be completed.
Return this form to 653 W Pratt St Baltimore, MD 21201 **OR** emeds-support@miemss.org

DO NOT SHARE YOUR USERNAME/PASSWORD WITH ANYONE.

HEALTHCARE FACILITY, HOSPITAL OR TRAUMA / SPECIALTY REFERRAL CENTER INFORAMTION

Facility Name

Health Care Facility Code

☐ MD ☐ DE ☐ PA ☐ VA ☐ WV ☐ DC

State – Circle 1

If Maryland Select County of Healthcare Facility Location

☐ Allegany Cnty – Reg. I	☐ Charles Cnty – Reg. V	☐ Prince George's Cnty – Reg. V
☐ Anne Arundel Cnty – Reg. III	☐ Dorchester Cnty – Reg. IV	☐ Queen Anne's Cnty – Reg. IV
☐ Baltimore City – Reg. III	☐ Frederick Cnty – Reg. II	☐ Somerset Cnty – Reg. IV
☐ Baltimore Cnty – Reg. III	☐ Garrett Cnty – Reg. I	☐ St. Mary's Cnty – Reg. V
☐ Calvert Cnty – Reg. V	☐ Harford Cnty – Reg. III	☐ Talbot Cnty – Reg. IV
☐ Caroline Cnty – Reg. IV	☐ Howard Cnty – Reg. III	☐ Washington Cnty – Reg. II
☐ Carroll Cnty – Reg. III	☐ Kent Cnty – Reg. IV	☐ Wicomico Cnty – Reg. IV
☐ Cecil Cnty – Reg. IV	☐ Montgomery Cnty – Reg. V	☐ Worcester Cnty – Reg. IV

INDIVIDUAL REQUESTING PASSWORD

~PLEASE WRITE LEGIBLY~

First Name

Last Name

Department

Title / Position

*Healthcare Facility Assigned E-Mail Address - **REQUIRED**

As the individual named above in this section, I understand that I have been given a copy of the Healthcare Facility's MOU regarding eMEDS® HOSPITAL HUB™ and understand all sections as they are written and will abide by conditions stated.

Signature: _____ *Date:*

APPROVAL REVIEW

Primary or Secondary Contact

Printed Name

Signature

Date

Form Revised 07/30/2019