

**MN VRV2000 USER ID APPLICATION
FUNERAL DIRECTOR**

<i>(Type or Print)</i>	<i>(First)</i>	<i>(Middle Initial)</i>	<i>(Last)</i>
Funeral Director:			
License Number:			<input type="checkbox"/> Request User ID
Funeral Home:		Address:	
License Number:			
I have been authorized by the funeral home named above to have access to the MN VRV2000 system. I authorize the following staff access to the MN VRV2000 system to enter fact of death information on my behalf. I understand that my name will be entered as the funeral director who provided the fact of death information.			
Signature:			Date:

DESIGNATED STAFF

<i>(Type or Print)</i>	<i>(First)</i>	<i>(Middle Initial)</i>	<i>(Last)</i>
Name:			
E-mail Address:		Phone Number:	
By signing this application I acknowledge that sharing my password or logging into MN VRV2000 with <u>any</u> other password other than my own is a breach of system security and may result in the suspension of my system privileges.			
Signature:			Date:
<i>(Type or Print)</i>	<i>(First)</i>	<i>(Middle Initial)</i>	<i>(Last)</i>
Name:			
E-mail Address:		Phone Number:	
By signing this application I acknowledge that sharing my password or logging into MN VRV2000 with <u>any</u> other password other than my own is a breach of system security and may result in the suspension of my system privileges.			
Signature:			Date:
<i>(Type or Print)</i>	<i>(First)</i>	<i>(Middle Initial)</i>	<i>(Last)</i>
Name:			
E-mail Address:		Phone Number:	
By signing this application I acknowledge that sharing my password or logging into MN VRV2000 with <u>any</u> other password other than my own is a breach of system security and may result in the suspension of my system privileges.			
Signature:			Date:

Please retain a copy for your records.

Rev. 11/2005

Return form to: Minnesota Department of Health
Office of the State Registrar
P.O. Box 64882
St. Paul, Minnesota 55164-0882
OR
FAX to: 651-201-5740