

# MR&C USER ID APPLICATION

## Local Registrar

- Instructions: 1. Use this form to add users, to change information about a user, or to delete a user from the system.  
 2. Check the option required.  
**\*\*3. Do not combine more than one type of request (New, Change, Delete) per form.**  
 4. There are blocks for additional staff on the back.

<input type="checkbox"/> <b>NEW (Add user to system.)</b>	<input type="checkbox"/> <b>CHANGE (Complete name and information that has changed.)</b>
<input type="checkbox"/> <b>DELETE USER ID - SUSPEND ALL RIGHTS</b>	Effective _____ (Date)

### LOCAL REGISTRAR

**Type or Print Clearly**

<i>(First) (M. I.)</i>	<i>(Last)</i>	
Local Registrar:		Phone:
County:	Address:	E-mail:
Office:	Office Request: <input type="checkbox"/> Group User ID <input type="checkbox"/> Public User ID	
<input type="checkbox"/> Add /Modify/Replace	<input type="checkbox"/> Administrative /Report	<input type="checkbox"/> Issuance Only
I authorize the following staff access to the vital records system to enter information as authorized below on my behalf.		
Signature:		Date:

### DESIGNATED STAFF

**Type or Print Clearly**

<i>(First)</i>	<i>(Middle Initial)</i>	<i>(Last)</i>
Name:		
E-mail Address:		Phone:
<input type="checkbox"/> Add/Modify/Replace	<input type="checkbox"/> Administrative/Report	<input type="checkbox"/> Issuance Only
By signing this application I acknowledge that sharing my password or logging into MR&C 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>(First)</i>	<i>(Middle Initial)</i>	<i>(Last)</i>
Name:		
E-mail Address:		Phone:
<input type="checkbox"/> Add/ Modify/Replace	<input type="checkbox"/> Administrative/Report	<input type="checkbox"/> Issuance Only
By signing this application I acknowledge that sharing my password or logging into MR&C 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:

Retain a copy for your records

Return form to:

Minnesota Department of Health  
 Office of the State Registrar  
 ATTN: State Registrar  
 P.O. Box 64882  
 St. Paul, Minnesota 55164-0882

**DESIGNATED STAFF (continued)****Type or Print Clearly**

<i>(First)</i>	<i>(Middle Initial)</i>	<i>(Last)</i>
Name:		
E-mail Address:		Phone:
<input type="checkbox"/> Add/Modify/Replace	<input type="checkbox"/> Administrative/Report	<input type="checkbox"/> Issuance Only
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Signature:		Date:

<i>(First)</i>	<i>(Middle Initial)</i>	<i>(Last)</i>
Name:		
E-mail Address:		Phone:
<input type="checkbox"/> Add/Modify/Replace	<input type="checkbox"/> Administrative/Report	<input type="checkbox"/> Issuance Only
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Signature:		Date:

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Signature:		Date:

<i>(First)</i>	<i>(Middle Initial)</i>	<i>(Last)</i>
Name:		
E-mail Address:		Phone:
<input type="checkbox"/> Add/Modify/Replace	<input type="checkbox"/> Administrative/Report	<input type="checkbox"/> Issuance Only
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ATTN: State Registrar  
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St. Paul, Minnesota 55164-0882