Data Manager Access Amendment Form

Complete this form each time you want to request an amendment to the existing access available to your nominated Data Manager. You may terminate your Data Manager's access, remove or allocate additional hospitals for which your Data Manager is authorised to enter new cases, view and edit retrospective data.

Please complete and return to BreastSurgANZ Quality Audit Helpdesk at breast.audit@surgeons.org or fax to +61 8 8219 0999.

DATA MANAGER DETAILS

Please provide the details of your Data Manager.

Full Name: ________________________________

Email Address: _____________________________

TERMINATE/AMEND DATA MANAGER ACCESS

[To be completed by Surgeon(s)]

Completing the below indicates you consent to the amendment requested. Ticking 'Remove' checkbox next to [Surgeon Name] will remove access to ***ALL*** *hospitals associated with the surgeon.*

ADD **REMOVE**

ADD	REMOVE		
	☐	Surgeon Name: ______________________	[signature]
☐	☐	Hospital (1): _____________________________________	
☐	☐	Hospital (2): _____________________________________	
☐	☐	Hospital (3): _____________________________________	
☐	☐	Hospital (4): _____________________________________	Date:________________

ADD	REMOVE		
	☐	Surgeon Name: ______________________	[signature]
☐	☐	Hospital (1): _____________________________________	
☐	☐	Hospital (2): _____________________________________	
☐	☐	Hospital (3): _____________________________________	
☐	☐	Hospital (4): _____________________________________	Date:________________

ADD **REMOVE**

☐ Surgeon Name: ______________________

☐ ☐ Hospital (1): _____________________________________

☐ ☐ Hospital (2): _____________________________________

☐ ☐ Hospital (3): _____________________________________

☐ ☐ Hospital (4): _____________________________________

[signature]

Date:________________

☐ Surgeon Name: ______________________

☐ ☐ Hospital (1): _____________________________________

☐ ☐ Hospital (2): _____________________________________

☐ ☐ Hospital (3): _____________________________________

☐ ☐ Hospital (4): _____________________________________

[signature]

Date:________________

☐ Surgeon Name: ______________________

☐ ☐ Hospital (1): _____________________________________

☐ ☐ Hospital (2): _____________________________________

☐ ☐ Hospital (3): _____________________________________

☐ ☐ Hospital (4): _____________________________________

[signature]

Date:________________

☐ Surgeon Name: ______________________

☐ ☐ Hospital (1): _____________________________________

☐ ☐ Hospital (2): _____________________________________

☐ ☐ Hospital (3): _____________________________________

☐ ☐ Hospital (4): _____________________________________

[signature]

Date:________________

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Developed by the Royal Australasian College of Surgeons, version June 2022.