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Patient Safety Data Reporting User Authorization Form

Facility Name: _____ Facility ID #: _____

New PSDR Primary User Information:

First Name: _____ Email: _____

Middle Name: _____ Title: _____

Last Name: _____

Suffix: _____

I authorize this individual to be added as my facility's primary PSDR user account.

Medical Director Name

Medical Director Signature

Date

Please submit this form via fax or email (preferred methods) or mail to the AAAASF PSDR Team for the change to be made to your PSDR account.

Email: helpdesk@aaaasf.org

Fax: (229) 394-4703

Mail: AAAASF
Attn: PSDR
7500 Grand Ave, Suite 200
Gurnee, IL 60031