

# PrimeroEdge

# New User Authorization

# Request Form

# Teaching and Learning Support

## Child Nutrition Programs

801 West 10th Street, Suite 200

PO Box 110500

Juneau, Alaska 99811-0500

907- 465-8708

FAX 907-465-8910

Instructions: Fill out this form and e-mail or fax it to Child Nutrition Programs (CNP). Retain a copy for your files. All School Food Authority (SFA) staff who needs access to PrimeroEdge (PE) must fill out this form. Complete a separate form for each user. Do not share your username or password with anyone.

Representing Sponsor/Agency Name(s):      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

New User Information:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_     \_\_\_\_\_\_\_\_\_\_     \_\_\_\_\_\_\_\_\_\_\_\_\_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Name First Name Middle Initial Title

     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_     \_\_\_\_\_\_\_\_\_\_     \_\_\_\_\_\_\_\_\_\_\_\_\_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing address City State Phone Number

New user email:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
*We will e-mail you your username and password.*

Check type of access:

Menu Planning

Student Eligibility

SFA Administrator

AGREEMENT: PrimeroEdge (PE) will assign a password to me and I agree to change it to a unique and secure password that only I will know and use. I understand that using the user name to submit data on the PrimeroEdge website is the same as an original signature for purposes of official documentation. By using the user name and password, I certify that the information sent to CNP is complete and accurate.

* I will not share my user name and password in order to maintain the integrity of the data. If another user uses the PE Web under my user name and password and provides false information, I understand that I will be responsible for the information supplied to CNP.
* I will notify the CNP immediately if my user name and password have been compromised. CNP will give me a new user name and password.
* If I no longer need access to the CNP Web, I understand that it is my responsibility to submit a form to end access.

     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_     \_\_\_\_\_\_\_

New User Signature Name (Please Print) Date

     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_     \_\_\_\_\_\_\_\_\_

Signature (Director/Business Manager) Name (Please Print) Date

Contact number for Director/Business Manager:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NOTE: Please update your User Authorization Request forms as often as changes occur to reflect only those currently approved to view or enter data and/or approve claims.

State Official Use Only:

Authorization request completed by:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:      \_\_\_\_\_\_\_\_\_\_\_\_\_

Confirmed changes by email, check all that apply:

New User: ID:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Password:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Updated:  Email  Phone Number

Access  Added/Removed:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_