Gojji Professional Account
Clinic Portal Access Authorization Form

P: 909-693-3376   Fax: 909-494-5582 Email: **provider@gojji.com**

The following authorization form must be completed by authorized agent(s) to be granted access to Gojji's Clinic Portal for clinics and/or providers. The Clinic Portal provides valuable information about your patient's diabetes health status:

- 360 view of all blood glucose readings (date, time and pre or post prandial)
- All glucose reading alerts, including Hypo and Hyper-glycemic alerts
- Longitudinal view of glucose trends and patterns

Please provide the information below and fax back to 909-494-5582, email to provider@gojji.com or provide it to a Gojji provider representative. Once Gojji has received your request for portal access, your clinic's portal access credentials will be sent via email within 3 to 5 business days.

Primary Clinic Information

Medical Group/Clinic Name:____

Primary Clinic Address:____

Primary Clinic Phone:__________________________ Primary Clinic Fax:____________________________

I certify that I am a physician or an authorized personnel representing the clinic mentioned above and authorizing the following user log-ins.

Authorizer Name:____________________________________ Authorizer Role:______________________

Authorizer Signature:_________________________________ Today's Date: ________________________

Please complete the following form to gain access to Gojji's Clinic Portal.

User Information: any health care team member (i.e. medical assistants, nurses, registered dietitians, pharmacists, physician assistants, nurse practitioners or doctors) that needs access to the Gojji Clinic Portal to manage their patients.

Provider Information: providers that are prescribing the gojji multi-functional meter and testing supplies. Please note that in order to see your patients in the clinic portal, all prescribing providers must be linked to the clinic portal or you will not be able to see your patients and their testing readings.

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User Information

1. User Name:________________________ Cell Phone #:____________________
   Email Address:____
2. User Name:________________________ Cell Phone #:____________________
   Email Address:____
3. User Name:________________________ Cell Phone #:____________________
   Email Address:____
4. User Name:________________________ Cell Phone #:____________________
   Email Address:____
5. User Name:________________________ Cell Phone #:____________________
   Email Address:____
6. User Name:________________________ Cell Phone #:____________________
   Email Address:____
7. User Name:________________________ Cell Phone #:____________________
   Email Address:____
8. User Name:________________________ Cell Phone #:____________________
   Email Address:____
9. User Name:________________________ Cell Phone #:____________________
   Email Address:____
10. User Name:________________________ Cell Phone #:____________________
    Email Address:____
11. User Name:________________________ Cell Phone #:____________________
    Email Address:____
12. User Name:________________________ Cell Phone #:____________________
    Email Address:____
13. User Name:________________________ Cell Phone #:____________________
    Email Address:____
14. User Name:________________________ Cell Phone #:____________________
    Email Address:____

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Additional Providers & Clinic Information

1. Provider Name: ____ NPI: _________________________
   Clinic Address: ____
   Clinic Phone: ____ Clinic Fax:_____________________
2. Provider Name: ____ NPI: _________________________
   Clinic Address: ____
   Clinic Phone: ____ Clinic Fax:_____________________
3. Provider Name: ____ NPI: _________________________
   Clinic Address: ____
   Clinic Phone: ____ Clinic Fax:_____________________
4. Provider Name: ____ NPI: _________________________
   Clinic Address: ____
   Clinic Phone: ____ Clinic Fax:_____________________
5. Provider Name: ____ NPI: _________________________
   Clinic Address: ____
   Clinic Phone: ____ Clinic Fax:_____________________
6. Provider Name: ____ NPI: _________________________
   Clinic Address: ____
   Clinic Phone: ____ Clinic Fax:_____________________
7. Provider Name: ____ NPI: _________________________
   Clinic Address: ____
   Clinic Phone: ____ Clinic Fax:_____________________
8. Provider Name: ____ NPI: _________________________
   Clinic Address: ____
   Clinic Phone: ____ Clinic Fax:_____________________
9. Provider Name: ____ NPI: _________________________
   Clinic Address: ____
   Clinic Phone: ____ Clinic Fax:_____________________

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ADDITIONAL PROVIDERS & CLINIC INFORMATION

10. Provider Name: ____________________ NPI: ____________

Clinic Address: ____________________

Clinic Phone: ____________________ Clinic Fax:____________

11. Provider Name: ____________________ NPI: ____________

Clinic Address: ____________________

Clinic Phone: ____________________ Clinic Fax:____________

12. Provider Name: ____________________ NPI: ____________

Clinic Address: ____________________

Clinic Phone: ____________________ Clinic Fax:____________

13. Provider Name: ____________________ NPI: ____________

Clinic Address: ____________________

Clinic Phone: ____________________ Clinic Fax:____________

14. Provider Name: ____________________ NPI: ____________

Clinic Address: ____________________

Clinic Phone: ____________________ Clinic Fax:____________

15. Provider Name: ____________________ NPI: ____________

Clinic Address: ____________________

Clinic Phone: ____________________ Clinic Fax:____________

16. Provider Name: ____________________ NPI: ____________

Clinic Address: ____________________

Clinic Phone: ____________________ Clinic Fax:____________

17. Provider Name: ____________________ NPI: ____________

Clinic Address: ____________________

Clinic Phone: ____________________ Clinic Fax:____________

18. Provider Name: ____________________ NPI: ____________

Clinic Address: ____________________

Clinic Phone: ____________________ Clinic Fax:____________

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