

# BERT FISH MEDICAL CENTER

## INFORMATION SYSTEMS –SECURITY ACCESS REQUEST FORM

Please print, complete and return to Bert Fish IS Department

FAX: 1-386-424-6366

PHONE: 386.424.5000 x 3612

“By faxing this request for access to BFMC applications and services you are agreeing to send the original signed copy of this access form to the Information Systems Security Office via inter-office or regular mail within a period not to exceed 1 week.

**ALL Applicable fields need to be completed or access will not be granted. If the required information is not provided, the forms will be returned to the requesting director.**

<b>Information</b>			Request Date: _____
Request Type: <input type="checkbox"/> New	<input type="checkbox"/> Change	<input type="checkbox"/> Terminate Date: _____	
Work Force Type: <input type="checkbox"/> Employee	<input type="checkbox"/> Vendor/Entity: _____		
<input type="checkbox"/> Auxiliary	<input type="checkbox"/> Student	<input type="checkbox"/> Instructor	
<input type="checkbox"/> Physician	<input type="checkbox"/> Physician Office Staff: (practice name): _____		
*****			
Name Last: _____	First: _____	MI: _____	Nickname: _____
Former Name (if applicable): _____			
Last 4 SSN: _____	Mother’s Maiden Name: _____	DOB: _____	
<b>Applicant Signature:</b> _____			Date: _____

Requested Access	
Network Access (Windows & Email)	
<input type="checkbox"/> Network	<input type="checkbox"/> Xceedium <input type="checkbox"/> Internet
<input type="checkbox"/> Email	<input type="checkbox"/> Other: _____
BFM Applications:	
<input type="checkbox"/> Meditech:	Make Like User Mnemonic: _____ (Contact IS for special requests)
Valco Viewer:	<input type="checkbox"/> Clinical <input type="checkbox"/> HIS Deficiencies <input type="checkbox"/> Business Office
Access eForms	<input type="checkbox"/> Repository <input type="checkbox"/> eSignature
<input type="checkbox"/> CoPath:	Contact the Laboratory Directly <input type="checkbox"/> Dictation: Contact HIM Directly
<input type="checkbox"/> Pyxis:	Contact the Pharmacy Directly <input type="checkbox"/> PACS: Contact Radiology Directly
<input type="checkbox"/> Other: _____	
<input type="checkbox"/> Shared Folder(s) _____	<u>Circle required permissions:</u>
	Read Add Change Delete Full
	Read Add Change Delete Full

Authorization:	
Applicant Job Title/Position: _____	License: (MD, RN, LPN, etc): _____
Dept/Office Phone #: _____	Department No & Name: _____
<b>Department Director Signature:</b> _____	Date: _____ Phone: _____
<b>Department Director Printed Name:</b> _____	

**Properly completed requests are subject to a 24 – 72 hour turnaround during normal business days**



**Computer Access Agreement**  
**Refer to policies: MI 73 & MI 41**

Use of the access code(s) and/or PIN will allow you to gain access to certain computer systems and computer-based information you are being authorized to use. By accepting the code(s) and/or PIN, you acknowledge that BFMC computers are for BFMC business use only.

I understand that my user access code(s) will be deleted from the system when I terminate employment or my relationship with Bert Fish Medical Center. Should I be re-employed or re-establish a relationship with Bert Fish Medical Center and it require a user access code, a new code will be issued at that time by the Information Systems Department.

I understand that violating Bert Fish Medical Center policy may result in denial of access privileges and/or disciplinary action, which may include termination of employment or other sanctions applicable to my relationship with Bert Fish Medical Center.

1. My user access code and/or PIN number is the equivalent of my signature.
2. My user access code and/or PIN number will not be disclosed to anyone.
3. I will not attempt to learn or use another's users' access code and/or PIN number.
4. I will not attempt to access any unauthorized information, or use systems outside the scope of my authority or responsibility.
5. I will log off the application when I have retrieved the information needed.
6. I will not leave any application open or the workstation unlocked when I am not present at the workstation.
7. If I have reason to believe that confidentiality of my user access code(s) and/or PIN number has been compromised, I will immediately report this to my director/supervisor or manger and will contact the Information Services department for assistances as needed to set new access code(s) and/or PIN numbers.
8. I understand that all activity recorded under my access code and/or PIN number will be ascribed to me. I also understand that should I forget and access code(s) and/or PIN number, it may be necessary to assign a new code.
9. I understand that I am subject to random audits at the discretion of Bert Fish Medical Center.

**Internet Agreement**  
**Refer to Policy: MI 73**

BFMC computers are for BFMC business only. Computers and communications systems, and the information stored thereon may not be used for personal business or in violation of any law or regulation. This policy also applies to internet use.

1. My user access code(s) and/or PIN number will only be used for permitted activities as described in policy MI 73 for Bert Fish Medical Center business.
2. I will not engage in prohibited activities.

**My signature below confirms that I have read, been given an opportunity to ask questions and understand the Bert Fish Medical Center referenced policies MI 73 & MI 41.**

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

Employee  Physician  Consultant/Vendor: \_\_\_\_\_

**Printed name:** \_\_\_\_\_ **Last 4 SSN/ID#:** \_\_\_\_\_<sup>1</sup>

<sup>1</sup> Policy Manager: MI F73



**ELECTRONIC MESSAGING AGREEMENT**

**(Please return this original signed copy to the Information Systems Department)**

- I understand that BFMC electronic mail, facsimile, answering machine and voice mail systems (collectively referred to as electronic messaging systems) are BFMC property and are to be used for BFMC business only.
- I understand that use of BFMC electronic messaging systems for the conduct of personal business is strictly prohibited.
- I understand that BFMC reserves the right to access, review, and disclose information obtained through electronic messaging systems at any time, with or without advance notice to me and with or without my consent.
- I understand that I am required to notify my supervisor or other BFMC official should I become aware of misuse of an BFMC electronic messaging system.
- I have read this agreement as well as the Email Use and Retention Policy, MI 34 in Policy Manager and have had an opportunity to ask questions about them.
- I agree to abide by the terms of the BFMC Email Use and Retention Policy.

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**I AGREED TO ON THIS DATE:** \_\_\_\_\_

Signature: \_\_\_\_\_

Department: \_\_\_\_\_

Last four digits of SS#: \_\_\_\_\_

Printed Name: \_\_\_\_\_

For Information Systems only:

Account Names: \_\_\_\_\_

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<sup>1</sup> Policy Manager: MI F34