Information Services
Support Center

Resurrection Health Care
Resident and Medical Student System Access Security Agreement

Section I **System Access** This document must be completed and signed by the applicant, then signed by the applicant's authorizing Residency Program Director or Medical Education Director to initiate a request for physician portal system access. Final approval is at the discretion of the sponsoring RHC Officer. Each applicant must also attach a signed RHC Confidentiality Statement (W-192).

Section II **General Information**

☐ ~~I am a RHC Resident~~ ☐ I am a Medical Student Residency or Medical Student Program End Date (M M D D Y Y)

☐ I am a Rotating Resident ☐ I am a Physician Assistant Student School Affiliation

Applicant's Name

Last Name First Name Initial

RHC Affiliation: ☐ OLR ☒ RMC ☐ SFH ☐ SJH ☐ WH ☐ HFMC ☐ SMNHC ☐ SEH ☐ Other:

~~Information Access:~~ ☐ ~~I Need Remote Access to Physician Portal (RHC Residents Only)~~ ☐ ~~Additional System Access Required (IS System Access Request Form Attached)~~

Challenge Questions: This information is requested for security purposes and is used to validate the end users identity in the event that passwords or system access must be reset or changed.

Last 4 Digits of SSN Mother's Maiden Name

Birth Date (M M D D Y Y) High School Name

Section III **Security Agreement Terms - Read and understand before signing! By signing this document you agree that you:**

"Check" each box indicating agreement to each term

Incomplete forms will NOT be processed

☐ accept this document as a legal contract and agree to use all system and information access for its intended use and purpose only. The approval of this system connection is specifically limited by your designated purpose, and will not be shared, publicly installed, or made available to others.

☐ understand that your Logon ID and password constitute your electronic signature. Your assigned Logon ID and password must be kept confidential. In the event that you suspect or know that someone other than yourself has knowledge of them, you must notify Information Systems.

☐ will not allow any unauthorized access using your Logon ID. This is regarded as a breach of confidentiality and medical ethics. Access attributed to your Logon ID as recorded in the system logs will be presumed to have been made by you.

☐ understand that all access and information provided is subject to professional confidentiality obligations, state and federal laws, including but not limited to federal HIPAA laws regarding the use and disclosure of protected health information. You agree to abide by and comply with these regulations, state law and professional obligations.

☐ confirm your knowledge that under information privacy and protection policy you are prohibited from transferring data in any format or form, from the host system to any other entity, system, or personal use system or record without express written authority to do so. This includes printouts, data transfers or database storage systems.

☐ agree that any indication of misuse will suspend or terminate access and could result in action under the rules of the residency program, civil legal actions, state and/or federal penalties and fines.

☐ understand that when a security token hardware device is provided for remote access to the RHC network, and the device remains the property of RHC. The applicant is responsible for the security token device, and any lost or damaged tokens will be replaced at the users expense. The applicant is required to return the token device upon termination of their remote access privileges.

Section IV **Applicant's Acceptance Statement and Signature**

I, _____, as the undersigned applicant accept and agree to all of the terms in this system access security agreement.
Print Applicant's Name

Applicant's Signature Date Telephone Number

Section V **Authorization Statement and Signatures**

I, _____, as the undersigned do approve and request system access for
Print Authorizing Director's Name
this applicant. I accept responsibility for compliance with the terms of this agreement. I will promptly notify RHC ISSC of any suspected misuse or breach, and of any need to modify access to the RHC System (ie: Staff Termination or Transfer).

Authorizing Director's Signature Date Telephone Number

RHC Officer Signature Date Telephone Number

Section VI **Information Services Use Only**

Network Logon ID Token SN # (if assigned)

STAR ID's STAR Group ID

Care Mgr ID Physician Portal Group

(RSASA-9300 06/03)

The applicant and the applicant's authorizing Residency Program Director or Medical Education Director both must sign this form before returning it to the I.S. Support Center for processing. Some applicants may require the sponsoring RHC Officer to sign the form to approve the request before submitting it to the I.S. Support Center for processing. Original signatures are required, photocopies and faxes will not be accepted or processed.