Beth Israel Deaconess Medical Center
BIDMC, HMFP and APG Staff Access Request Form

All access requests for BIDMC, HMFP, APG staff and affiliates must be completed and signed by the sponsoring departmental manager/director and must include the specific access level required. By default, users are granted the most restrictive level of access. All Accounts unused for 90 days or more will be disabled. Access can only be restored by completing this form.

Requests will be processed within 3 business days of receipt **FAX to BIDMC IS SUPPORT at 617-754-8099**

TO BE COMPLETED BY Requestor (Please print clearly and fill out form **completely**) **Date of Request:** _____

Type of Request: ☒ New Account ☐ Change Privileges ☐ Disable Account ☐ Re-enable Account

Affiliation: ☐ **BIDMC** ☐ **HMFP** ☐ **APG** ☐ **Other: Specify:** _____

Personnel Information:

Name: _____
Last Name *First Name* *Middle Initial*

Title: _____ **Employee ID**: N/A
(If applicable)

Department: Medicine **Specialty**: _____ **Dept Cost Center**: Med
(If applicable)

Date of Birth: _____ **SSN**: (Last 4-digits ONLY) _____ **SEX**: ☐ Male ☐ Female

Employee Type: ☒ Full Time ☐ Part- Time ☐ Per-Diem ☐ Temp/Student/Contract ***Employee Begin Date:*** 6/20/2011 ***Employee End Date:*** _____

Work Location: (Building/Floor/Room) W. Deac 300 **Work Phone**: 2-8266

(Practice Address, if applicable: _____ (Street)
_____(City)

TO BE COMPLETED BY AUTHORIZING BIDMC SPONSOR/MANAGER (Please print clearly and fill out completely)

Name (please print): Crawford Andrea
Last Name *First Name* *Middle Initial*

Title: Program Coordinator **Work Phone**: 2-8266

Signature: Andrea Crawford

Account Request Information: ***(Check all that apply)***

☒ **Clinical Computing (CCC) / CareWeb Access**

☒ WebOMR Access
- ☒ If Clinician, is ability to sign op/discharge notes needed?
- ☐ If Nurse/Support Staff, is ability to place orders needed?

☐ Specialized Subsystems (OPD Reg, Appt. Scheduling, etc) **must be specific:** POE, Cath Lab White Board-read only access

☒ **ITS/ Domain Login**, with Personal Network Directory Storage (H:\ Drive) and Outlook Email
***Note**: Home directories should **not** contain any non business-related materials such as photos, music or video files*

☐ **Network Share Access (S:\ Drive)**

Specify Share Name: _____ **Level of Access**: ☐ **Read** ☐**Read/Write/Modify**

☐ **Departmental Applications, if applicable**: _____
_____

CareGroup
Healthcare Systems

CONFIDENTIALITY ACKNOWLEDGMENT

Any information learned during the performance of one's work at CareGroup or any of its affiliates (hereinafter "CareGroup") which is not commonly available to the public must be kept confidential. This applies to information about patients, employees, and medical staff, research, and business affairs. Further, this applies to information in any form - spoken, written or electronic.

Each individual working in the CareGroup environment is responsible for protecting the privacy of our employees, our staff, and our patients, and must take care to preserve confidentiality in conversations and in handling, copying, faxing, and disposing of documents. Unusual activity or behavior, which could threaten confidentiality, should be questioned and reported.

Access to CareGroup information is permitted only as required for the performance of one's job. For example, reading confidential information not directly required for job performance, even if that information is not further disclosed, is a violation of policy and is, therefore, strictly prohibited. All policies and procedures related to authorization and access to confidential information must be followed.

Only people with an officially granted account may access CareGroup computer systems and networks requiring passwords. Each person is responsible for maintaining confidentiality by never sharing passwords or access and by always locking or logging off a terminal or workstation when leaving the area. Each person is accountable for all activity occurring under his/her account, password, and/or electronic signature. Such activity may be monitored.

Disclosure of CareGroup confidential information is prohibited except when required for the performance of one's job for CareGroup and when specifically authorized. Disclosure of confidential information is prohibited indefinitely, even after termination of employment or business relationship, unless specifically waived in writing by an authorized party.

I certify that I have received and read this Confidentiality Acknowledgment and understand the requirements set forth in it. I understand that I will be subject to disciplinary action, up to and including termination of my employment, professional privileges, and business relationships, for violating CareGroup policies or failing to report violations of CareGroup policies.

_____	_____
Printed Name	Title
_____	_____
Signature	Date
Andrea Crawford	Program Coordinator
Supervisor's/Sponsor's Printed Name	Title
Andrea Crawford	February 22, 2011
Supervisor's/Sponsor's Signature	Date

CAREGROUP
Request for Radiology PACS Access

TO BE COMPLETED BY USER (Please Print)

Name_____ SSN (Last 4 Digits)_____
(last name first name middle initial)

Job Title: _____ **Phone** _____Pager E/W #_____

Department Medicine Location (Bldg,Flr,Rm) W. Deac 300

BIDMC Employee or Physician (Y/N) Y If not, name & address of employer:_____

Confidentiality Acknowledgement:
I am aware of and agree to abide by the policies regarding the confidentiality of CareGroup information, including:

- The unauthorized possession, use, copying, or reading of hospital records, or the disclosure of information contained in such records, or the disclosure to any unauthorized employees, is strictly forbidden. An employee may be terminated for failure to adhere to this policy.
- Information entered or activity in this system under my authorized user ID and password shall be my responsibility. My user ID and password are my signature. I **may not**:
  - Share my user ID and password with anybody;
  - Leave a device to which I have signed on without having signed off.
- Willful abuse or irregularity on my part including not keeping my password secret or pressuring another person to share a user ID and password shall be subject to disciplinary action.

Signature_____

Date_____/_____/_____

TO BE COMPLETED BY REQUESTOR'S AUTHORIZING MANAGEMENT (Please Print)

Date of request : _____Type of Request: New X Change_____Delete_____

If non-employee / non-staff: Start date_____End date (no more than 1yr)_____

Level of Access: Physician X Rad. Tech.___ Nursing___ Support Staff___

I authorize access to and use of this system as specified for the above-named person. I will inform the proper department or information security promptly if this person leaves or no longer needs this access.

Name (print) Andrea Crawford Job Title : Program Coordinator

Signature: Andrea Crawford Phone: 2-8266

Fax COMPLETED Form to:
Radiology (617) 667-4379 Attn: Jim Brophy or Phil Purvis

TO BE COMPLETED BY RADIOLOGY INFORMATION SYSTEMS PERSONNEL

Logon ID_____Processed by_____Date_____/_____/_____

CAREGROUP
HEALTHCARE SYSTEMS

Telecommunications Work Request & Pager Form

Request Contact: Contact Ext.: Fax:

Requested Date: / / Required Date: / /

Account/Cost Center #:

PLEASE CHECK: ***TELEPHONE*****:** π **New** π **Change** π **Move** π **Remove** π **Directory Change** π **Other**
(If Other, explain below) ***PAGER*****:** π **New** π **Name Change** π **Remove** **Replacement:** π **Broken** π **Lost/Stolen**

TELEPHONE:

	Existing Information	Proposed Information
Name:	/	
Campus/Building/Room:	/	
Department:	/	
Telephone Extension:	/	
Jack Number:	/	
Set Type:	/	

Check Hardware Required:
π Phone π Fax Line π Modem Line π Voice Mailbox π Headset π Speaker

Check Software Required:
π Pickup Group π Coverage Path 1. _____2._____3.______ π Add Feature ___________________________

Check Calling Capabilities Required:
π In-House π Local π Massachusetts π New England π United States

PAGER INFORMATION:

Name for Voice Prompt Pager ID # Code Team: π Yes π No

Remarks/Comments (add separate sheet if necessary):

Approval Signatures:
Requesting Employee or Contact: Date:

Dept. Manager/Telecom Coordinator: Date:

Fax completed forms to Telecommunications at (75)4-8199. For telephone repair or service-related questions, call the I.S. Support Center at (75)4-8080. Retain a copy of the request for your records.

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OFFICE USE ONLY:

Completed by: ______________________

Pager ID # Old 7-digit # New 7-digit #

Old Cap Code New Cap Code

Rev 7/19/00

Beth Israel Deaconess Medical Center

Public Safety Department

Photo ID & Access Card Authorization

NOTICE TO REQUESTOR – PLEASE READ FIRST:

Photo IDs are now printed onto access cards. Pictures for IDs are taken daily at the Public Safety Office on the West Campus in the Farr Building, 1st floor 24 hours a day, 7 days a week – Holidays included

You will be asked to provide another form of photo identification. A driver's license, official state identification or another form of official photo identification is required

There is a $5.00 replacement fee for lost or missing access cards. This fee is payable at the Cashier on Feldberg 2nd floor or Clinical Center West main lobby. A paid receipt must be presented along with this authorization form to obtain a new card & ID

ALL ITEMS MARKED WITH AN ASTERISK (*) ARE REQURED INFORMATION AND MUST BE FILLED IN PLEASE PRINT CLEARLY

PRE-SIGNED COPIES, FAXES OR OTHER OBVIOUS DUPLICATIONS OF THIS FORM WILL NOT BE ACCEPTED

AUTHORIZING SIGNATURE MUST BE AN ORIGINAL SIGNATURE

NOTE: PUBLIC SAFETY RESERVES THE RIGHT TO REFUSE THIS FORM IF THE ABOVE CRITERIA IS NOT MET

* Requesting (check one): __ ID Only ____ Access Card Only _X_ ID & Access Card Combo

* Last Name:_____ * First Name:_____ * Employee #: _____

*** FOR "MDs & PhDs" ONLY:** Designate if requestor is working in: _X_ Clinical ____ Research

* Clinical Designation (You may be asked for proof of Designation): PhD MD PsyD RN LPN RA OT PT NP SPM PA DDS DVM RT RD Rph MT MS CPP

* Department Name: Medicine

* Department Authorized By (PRINT): Andrea Crawford

Department Extension: 2-8266

* Authorizing Signature or HR Recruiter: Andrea Crawford

* EOHS Authorizing Signature _____

**Medical Students Only (Circle One): HMS Other

**If HMS, then no EOHS signature is required

* Date of Request: 6/20/2011 Term Ending Date: _____

* Clearances Requested (Buildings, Departments):

All

Public Safety Department Use Only Below This Line

ID Confirmed? (Circle One) Y N If "No", reason: _____

Type of ID shown:_____ Number: _____

Access Card Number Issued: _____ Key (Internal) #: _____

Date Issued: _____/_____/_____ Name of Officer Issuing Card: _____

Prior Clearance(s) Codes:

_____