Beth Israel Deaconess Medical Center
BIDMC/ HMFP Staff Access Request Form

All access requests for BIDMC/HMFP 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

Personnel Information:

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

Title: Medicine Resident **Employee ID**: _____ (If applicable) **Affiliation**: ☒ BIDMC ☐ HMFP

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

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

Employee Type: ☑ Full Time ☐ Part- Time ☐ Per-Diem ☐ Temp/Contract ***Employee Begin Date:*** 06/23/2010 ***Employee End Date:*** _____

Work Location: (Building/Floor/Room) Deac 311 **Work Phone**: _____

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

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

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

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

Signature: _____

Account Request Information: (Check all that apply)

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

☑ WebOMR Access

☑ Specialized Subsystems (Clin. Info. Appt. Scheduling, etc) **must be specific:** POE

☑ **ITS/ Domain Login**

☑ With MS Exchange Email Account

☑ With Personal Network Directory Storage (H:\ Drive)

***Note**: A person's home directory should **not** contain any non business-related materials such as photos, music or video files*

☐ With Network Share Access (S:\ Drive)

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

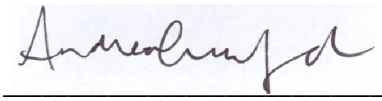
Each individual working in the CareGroup environment is responsible for protecting the privacy of our employees, our staff, and our patients, and must take care to preserve confidentiality in conversations and in handling, copying, faxing, and disposing of documents. Unusual activity or behavior, which 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	Intern Coordinator
Supervisor's/Sponsor's Printed Name	Title
	March 17, 2010
Supervisor's/Sponsor's Signature	Date