Mercy Hospital and Medical Center
Request for MAPS Access for Agency Staff Members

Name of person requesting access |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|
Last Name First Name

Last Four digits of Social Security Number |__|__|__|__| (required for password reset verification)

Agency: _____ Phone: _____

Agency Address: _____

Work Assignment Location

General In-Patient Unit _____
Obstetrical Services _____
Perioperative Services _____
Satellite Facility _____

Emergency Department _____
Therapy Services _____
Out-Patient Clinic _____
Respiratory Therapy _____

Pathology _____
Radiology _____
Admitting _____
EKG _____

I acknowledge and understand that:

1. I will establish a password for my log-in I.D within five days of receipt of this authorization form. I will keep this password and Log-in I.D. confidential allowing no one else to use it to access the computer.
2. I will not attempt to learn someone else's access code or attempt computer access with another log-in I.D.
3. I will notify Information Systems to change my password as required whenever I suspect that confidentiality has been broken. I understand that my password will automatically expire ninety days (90) after initialization and that a new password must be entered. Procedures covering log-ins and passwords are available in the department.
4. I understand that I am responsible to protect the patient's right to the utmost confidentiality of his/her medical information through the use of the computer system. I understand that I am not to access information that is not necessary to perform my assigned duties.
5. I agree to log off the systems prior to leaving my workspace.
6. I agree to use the computer, including the email system and the Internet, for Mercy business only.
7. I understand that my logon and password will expire after one year (12 months) and that I must submit a new access request form at that time.

I further understand that any agency staff member who knowingly breaches confidentiality through a violation of the policy statement outlined above is subject to immediate discharge and placement on the Do Not Use (DNU) list for the hospital.

Agency Staff Member Signature: _____ Date:_____

Nursing agencies send forms to Patient Care Services, attn: Megan Rasmussen.
<u>All others</u> send completed forms to department where applicant will be working.

Mercy Approval: _____ Date: _____
Signature

_____ _____ _____
Printed Name Department Extension/Pager

IS - send access codes to department approving access.

IS Use Only

Login Name: _____

Technician: _____ Date completed: _____