



LOMA LINDA
UNIVERSITY
MEDICAL CENTER

Loma Linda University Related Facilities MEDICAL STAFF COMPUTER ACCESS REQUEST/DELETE FORM

NAME OF PHYSICIAN/AHP (Please Print) _____, _____, _____

Add Sign-On(s) Modify from Res to Phys Last _____ First _____ MI _____

Disable All Sign-On(s) Physician/AHP Specialty _____

User Name Change (Marriage, legal name change) (Previous name) _____

(MSA Use Only) Facilities: _____ Email Group: MC BMC _____

EID# _____ Faculty Community

Faxed Date: _____ Degree: _____ Effective Date _____

Confidentiality Warranty

*I understand and agree that I am being issued a computer security code password. I hereby accept full responsibility of the use of this password and agree to adhere to, in accordance with, but not limited to, the requirements of LLUMC Policy A-34, "Computer Systems Security". In addition, I understand and agree to adhere to, in accordance with, but not limited to, the requirement of LLUMC Policy A-43, "Use of Computer Internet Services." Furthermore, I agree that I will not share this password with any other individual, nor will I use any other individual's password. In addition, I understand and agree that I assume full responsibility for all transactions and information available through the use of this password. I also agree to immediately notify the IS Help Desk at ext. 48889 if I learn that any other person obtained information which may provide them the opportunity to use my password. Furthermore, in accordance with, but not limited to, the requirements of LLUMC Policies A-10, "Classification and Protection of Information" and I-25 "Personnel Records", I understand and agree that I will have access to confidential information pertaining to patients, employees and business data which is the property of LLUMC. I also agree to be responsible for maintaining the confidentiality of such information. In addition to the above, for systems listed (denoted by an asterisk *) that allow for an electronic signature, I understand that the use of this password represents my electronic legal signature so that the use of this code is the same as my written signature. Finally, I understand and agree that any breach of confidentiality as stated herein and/or in accordance with LLUMC Policy or applicable law shall be grounds for disciplinary action, which may include immediate termination.*

Employee/Staff Signature: _____ **Date:** ____/____/____

Title: Physician Allied Health Professional **Department:** _____

Dictation #: _____ **For VPN ONLY:** **Cost Center:** _____ **Service Chief Initials:** _____

Admin Asst Contact Name: _____ **Ext:** _____ **Bldg/Room:** _____

CHAIS/CICS <input type="checkbox"/> DHIS <input type="checkbox"/> SUPERSESSION <input type="checkbox"/> TSO		<input type="checkbox"/> Web Insurance	<input type="checkbox"/> Passport
You must provide the name of an employee who has the same access _____		<input type="checkbox"/> TRAC / On-TRAC	<input type="checkbox"/> Optime
		<input type="checkbox"/> Charms	<input type="checkbox"/> AGFA RIS* (Radiology Only)
<input type="checkbox"/> TSO	<input type="checkbox"/> T&A (TSO required)	<input type="checkbox"/> MIDAS+	<input type="checkbox"/> Computrition
<input type="checkbox"/> LLUCIS (LLEMR-Pwr Cht)	<input type="checkbox"/> FirstNet* (EM, Med Only)	<input type="checkbox"/> DataEase/Transplant DB	<input type="checkbox"/> Periop: Surgery Schedule
<input type="checkbox"/> Outlook	<input type="checkbox"/> Bed Management	<input type="checkbox"/> Decision Support Portal	<input type="checkbox"/> VPN Access Cost center # _____
<input type="checkbox"/> OWL Portal	<input type="checkbox"/> Acustaf	<input type="checkbox"/> PMM	<input type="checkbox"/> HCMS
<input type="checkbox"/> IMPAX	<input type="checkbox"/> MestaMed	<input type="checkbox"/> No Internet Access	<input type="checkbox"/> ClinDoc
<input type="checkbox"/> Novell	<input type="checkbox"/> DTS	<input type="checkbox"/> ProgNotes (Peds & FM Only)	<input type="checkbox"/> TOROL/Quest Diagnostics
<input type="checkbox"/> DocuSys (Anesthesiologists only)		<input type="checkbox"/> ProgNotes (Peds & FM Only)	<input type="checkbox"/> CDL Apps (Cardiology Only)
<input type="checkbox"/> Shared Drive (provide folder name): _____		<input type="checkbox"/> Other: _____	
<input type="checkbox"/> HPF*		<input type="checkbox"/> MedQuest (All UHC)	
<input type="checkbox"/> Physician <input type="checkbox"/> Allied Health/Student/Nurse Practitioner/Phys Asst/Clinical Psychologist, etc			
(FOR PHYSICIANS/AHP ONLY) Additional signature required for PIN number/electronic signature			
<i>In addition to the above said statement under "Confidentiality Warranty", I am being issued a security code password that is my responsibility to maintain in a confidential manner. This password is for entering and using on-line Medical Center Information Systems and is my electronic legal signature. I have received a unique code in order to authenticate patient records at LLUMC. This code is functional for the HPF system. I understand that my use of this code is the same as my written signature. I will be the sole user of this code. I will not share this code with anyone else. I will not use anyone else's code. If anyone should obtain information, which would allow him or her to use my code, I will immediately notify the Help Desk at ext. 48889.</i>			
Signature: _____		Date: ____/____/____	

AUTHORIZED BY: (Signature) _____ (Print name) _____

(Authorization from Medical Staff Administration Only. All other signatures will cause a delay.)

Ext: _____ **Date:** ____/____/____

FAX TO Medical Staff Administration for Authorization and Processing Fax 66053

Office use only: USER ID _____ ANALYST INIT _____ DATE ____/____/____