

***Note: Fill only items marked with asterisk.**

IS Security Access Request & Agreement Form (SAR)

Applicant Type: <input checked="" type="checkbox"/> Business Associate (Includes Agency, Contractor, Vendor, Joint Venture) <input type="checkbox"/> Employee <input type="checkbox"/> Intern
Date: _____ *Group or Provider's Name: _____ Requested By: _____ Authorized By (Director Approval): _____ Name of Applicant: *Last Name _____ *First Name _____ *M _____ Department Name _____ Department Number _____ Supervisor Phone Number: _____ Employee Phone Number: _____ Port #/Location of User: _____ *Social Security No.: _____ Employee ID No. _____ Job Title: _____ FT or PT: _____ Shift: _____
For "Business Associates" ONLY: Name of Company: _____ Contract _____ Contract Expiration Date: _____ Date: _____
Request for Access: Information Services Access A. ID Badge Activation <input type="checkbox"/> New <input type="checkbox"/> Temporary <input type="checkbox"/> Replacement <input type="checkbox"/> Contractor B. Network Access (Check all that apply) <input type="checkbox"/> New Access <input type="checkbox"/> Update Access <input type="checkbox"/> Delete Access <input type="checkbox"/> Basic Network – includes a Network Acct, Network Printing capabilities, access to an "L" (personal drive), and Groupwise account (E-mail). <input type="checkbox"/> Internet – Includes CFHP and UHS Intranet <input type="checkbox"/> Shared User Directories: (please specify any directories/folders that user will need permission to access) <input type="checkbox"/> HSM Database <input type="checkbox"/> AboveHealth C. AMISYS <input type="checkbox"/> Issue New AMISYS Session Name <input type="checkbox"/> Update Existing AMISYS Session Name <input type="checkbox"/> Terminate AMISYS Session Name Termination As of Date: _____ CFHP Employee Information Access: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Terminate Copy Security Profile of: _____ D. Additional Applications: <input type="checkbox"/> Medifax <input type="checkbox"/> Care Enhance <input type="checkbox"/> Redbook <input type="checkbox"/> Visio <input type="checkbox"/> Adobe Acrobat Standard <input type="checkbox"/> Encoder Pro Telecommunications (Phone) Access <input type="checkbox"/> New Access <input type="checkbox"/> Update Access <input type="checkbox"/> Delete Access <input type="checkbox"/> Recorded Line Required Describe any special needs: _____ <input type="checkbox"/> Voice Mail Required _____
I, the undersigned, hereby acknowledge receipt of a UserID and passwords giving me access to the Information System of Community First Health Plans. I understand and acknowledge that this UserID and password combination is unique to me and is the electronic equivalent of my signature, with no difference in liability existing between my written and electronic signature. I further understand that this UserID and password may give me access to confidential member and physician information, employee personnel information, financial information and business information relating to the Community First Health Plans (hereinafter referred to as Information), and that Community First Health Plans regards maintaining the confidentiality of this information to be of paramount importance. Therefore, in consideration of the foregoing, I agree to the following:

1. **Information to be confidential.** All information obtained by me, or on my behalf, whether by me, my office staff, agents, employees or any other person whatsoever, will be maintained in confidence by me, or by any other person acting on my behalf. I further agree that information will be obtained and used only as necessary to perform my professional responsibilities.
2. **Scope of information.** I agree that I will use the UserID and password only to obtain access to that information necessary for me to perform my professional responsibilities.
3. **Use of UserID, Password, and Equipment.** I will not disclose my UserID and password to any person or entity, nor will I attempt to learn or use any other person's UserID and password. I also will not make any alternations to any equipment, this includes, but is not limited to:
 - Software/Hardware Installations
 - Software/Hardware Removals
 - Software/Hardware Configurations
4. **Issuance of New UserID and Password.** If I have any reason to believe that the confidentiality of my UserID and password has been compromised, I will notify the Information Systems Department immediately so that the suspect UserID and password may be deleted and a new UserID and password by assigned to me.
5. **Responsibility for Self.** I recognize that I am responsible for all actions performed at a workstation activated with my UserID and password; therefore, I will terminate the session before leaving the workstation.
6. **Responsibility for Others.** If applicable, I hereby specifically accept responsibility for ensuring that my office staff, agents, employees, or any other person acting on my behalf, in connection with information, will abide by the terms and conditions of this Confidentiality Agreement.
7. **Violation of Conditions.** I recognize that violation of any of these conditions may result in withdrawal of computer access, termination of employment for employees, denial of access for non-employees, and other disciplinary actions.

*IN WITNESS WHEREOF, I have executed this agreement on
 this _____ day of _____, _____.

INFORMATION SYSTEMS USER:

WITNESS:

Print:

_____ *Last Name *First Name *MI

Print:

_____ Last Name First Name MI

*Signature _____

Signature: _____

For IS Use ONLY

Network:

User ID: _____
 Groupwise E-mail address: _____

Date Access Granted/Terminated: _____

Granted by: _____

AMISYS:

Session Name: _____

Job No.: _____

Date Access Granted/Modified/Terminated: _____

Granted by: _____

AboveHealth:

User ID _____

Type of Access: _____

Date Access Granted/Modified/Terminated: _____

Granted by: _____

Telephone:

User Name: _____

Ext. _____

Date Access Granted/Modified/Terminated: _____