VA MEDICAL CENTER
LOUISVILLE, KY

APPENDIX A
MEMORANDUM NO. 603-07-008-002
May 1, 2007

REQUEST FOR ACCESS TO VAMC LOUISVILLE AUTOMATED INFORMATION SYSTEMS

RULES OF BEHAVIOR

1. As an authorized user of VA computer systems, I have been granted access to certain sensitive and privacy related information, and use of government computers to accomplish my assigned duties.

2. In exchange for this degree of access, I understand there are specific security policies and procedures that I must abide by to retain access. These include the following:

a. I am STRICTLY PROHIBITED from disclosing my access, security codes and/or electronic signature codes to ANYONE, including my family, friends, fellow workers, supervisors and subordinates for ANY reason. I understand that failure to abide by this requirement can result in charges of fraud and/or allowing unauthorized access to government systems.

b. I understand passwords are unique and individual in nature, that they identify me to the computer, and provide an audit trail of my computer actions. I understand that I am personally responsible for all actions performed under my assigned codes.

c. I will access patient records (veterans and/or employees) only in the performance of assigned duties.

d. I will not "browse" patient records of veterans, fellow employees, family members, and others known to be receiving healthcare at this facility to satisfy personal interest. Information about an individual is confidential and protected from disclosure by law (except for specific legal exceptions or with the individuals consent). Improper disclosure of information (obtained through the computer or otherwise) to anyone not authorized to receive it, may result in a fine and/or criminal prosecution under the Privacy Act of 1974 and applicable regulations.

e. I will access only authorized Internet sites. I understand that Internet access is specifically denied to any site that contains pornographic, illegal, hate, or criminal skill material.

f. I will not remove or transmit patient protected health information (PHI) from this facility for personal use or gain.

g. I will not transmit protected health information (PHI) over any unsecured communications media, or to any unauthorized individual or agency.

h. I understand that administrative and clinical information contained in the facility's computer systems is deemed confidential and privileged, and will not be disclosed to any unauthorized individual or agency.

i. I will properly sign off from any workstation before leaving it unattended. I understand that failure to sign off constitutes continued responsibility for any actions performed on that workstation under my set of codes.

3. I understand that any violation of this agreement constitutes disregard of a direct supervisory order and can result in disciplinary action, which may be administrative, criminal, or both. I further understand that my access may be terminated without prior notice if I am suspected of any security violations pending any investigations of the allegations.

4. I affirm that I have read, understand, and agree to the provisions and intent of this agreement. I further understand that the use of my electronic signature as acknowledgement has the same legal implications as a handwritten signature.

5. If you have any questions regarding this policy, please contact Donna Pearson, Information Security Officer at (502) 287-4000, ext. 55513.

I affirm with my signature that I have read, understand and agree to fulfill the provisions of this User Access notice.

Signature:_____ SSN:_____ Date:_____

PLEASE PRINT - The information provided should match EXACTLY what was recorded during the new employee in-processing. The name should be your LEGAL (payroll) name. If you prefer to be addressed by some other name, that provision is allowed under the NICKNAME field.

LAST NAME:_____ LEGAL FIRST NAME: _____ MIDDLE INITIAL: _____

INITIALS:_____ SSN:_____ SEX:_____ NICKNAME:_____

USER CLASS:_____ DEGREE:_____ PERSON CLASS V-CODE_____

NATIONAL PROVIDER IDENTIFIER (NPI)_____

JOB TITLE:_____ SERVICE:_____ MAIL CODE:_____

Date HIPAA Training Completed_____
Date Information Security Training Completed_____
Date Fingerprinted_____
Date Statement of Commitment and Understanding Signed_____
Non-VA Employees (Students, Residents, Volunteers) expected termination date_____

Section 1: **VISTA Access**

A. Primary Menu Name:_____

Secondary Menu Name:_____
Security Key(s):_____
Mail Groups:_____
Add Order Screen:_____

B. **If the degree of access to be granted is identical to another employee, that employee's name may be entered here and the identical primary and secondary menus, file manager codes, and security keys will then be assigned:**

_____

C Please indicate if dial-up access to VISTA will be required: YES_____ NO_____

Section 2: **Local Area Network Access**

Please check for a Local Area Network Account to be created and identify any associated applications.

- □ Establish a Local Area Network Account
- □ Establish an Electronic Mail Account (Outlook) Phone#_____

Section 3**: Approving Official (Service Chief, Administrative Assistant, or ADPAC).**

APPROVING OFFICIAL Signature:_____ DATE:_____

TITLE:_____ TELEPHONE:_____