

Applicant's Name		IH User ID (if known):		
		<input type="checkbox"/> Student	<input type="checkbox"/> Contractor / Consultant	
		<input type="checkbox"/> Agency	<input type="checkbox"/> Volunteer	<input type="checkbox"/> Termination
External Entity				City
Applicant's Position (for students, please specify program e.g. RN, LPN, etc)		IH Worksite and Department (e.g. Emerg, Peri, OR, MH)		Applicant Phone Number
IH Sponsor or Signatory Name from EALA		Sponsor / Signatory Email (will be used to contact annually to verify this user's status)		Sponsor / Signatory Phone Number
Date access required (dd/mm/yyyy)			If temporary position or termination enter date access to be inactivated (dd/mm/yyyy)	
Is MEDITECH required? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If Yes</b> , provide the name of a user with the same access required by this applicant (i.e. someone in a similar role)				
Remote Access required? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If Yes</b> , Business justification and list of applications/folders/required:				
Please choose a 4 digit Personal ID Number: _____ Please select something you will remember such as your month & day of birth. For example Jan 15 would be 0115 (mmdd). This number will be used to verify your identity should you require assistance from the Service Desk.				
**For Students & Contractors ONLY** Is OUTLOOK required? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, why?				

I acknowledge that all information to which I may have access to or learn about through my relationship with Interior Health is strictly confidential and not to be communicated to anyone in any manner except as authorized by IH policy and, when so authorized, it will be in compliance with the applicable laws and legislation. I further acknowledge that information is not to be copied, altered, printed, interfered with, destroyed or taken, except upon authorization and in accordance with established policy and legislation. I understand that compliance with confidentiality is a fundamental condition of my computer system access privileges and relationship with IH.

**By checking (☑) each statement, I indicate that I have read, understood and agree to abide by the following:**

- I acknowledge that my username and password is equivalent to my legal signature and is not to be shared with anyone. I will be held accountable for all activity performed under my access account. Upon loss or suspected disclosure of my password to another individual I will immediately inform the IH Service Desk at 1-855-242-1300 or email servicedesk@interiorhealth.ca.
- Upon completion of access to IH systems I will ensure that the remote session/workstation has been properly logged off. I will not leave my workstation logged on to IH systems and unattended unless locked.
- I will treat all electronically stored data and printed documentation as strictly confidential.
- I will only access data which relates directly to my job functions on a "need-to-know" basis and use such information only for and to the extent required by the business purposes I am authorized to perform.
- I will not access my personal health record or the health record of any member of my family, co-workers or any other individual for whom I am not providing direct care as a requirement of my employment. I understand that I can access my personal health information through other established procedures through appropriate Health Records Department.
- I will only share personal information with individuals who "need to know" and who are also involved in providing health care services to the patient/client/resident as a requirement of their employment.
- I will use my network access privileges in an ethical and professional manner, for the purpose of IH related business and/or as authorized by policy.
- I will not, by any methods, remove any electronic data or software from any IH facility without proper authorization.
- In the event of a suspected or confirmed privacy or security breach, I will immediately inform the IH Information Privacy & Security office at 1-855-980-5020 or email info.privacy@interiorhealth.ca during regular business hours. Afterhours I will contact the IH Service Desk at 1-855-242-1300.

I understand that in order to protect data confidentiality and integrity the IH Information Privacy & Security office conducts security audits, and that any misuse of my user ID and password, intentional or unintentional, violates this agreement and could subject me to disciplinary, legal and/or other actions by my employers, as well as revocation of IH network access. I further acknowledge that I have read and understand the below related policies and the IH policy concerning my responsibilities regarding [Privacy and Management of Confidential Information](#) (AR0400) obtained during the course of my employment, affiliation or assignment at IH and understand the consequences for breach of this policy.

**For legal purposes this form must be hand signed. Please complete, print, sign and forward to the Access Team using the contact information below.**

Date (dd/mm/yyyy)	Time (24 hour)	Applicant Name / Signature		
Date (dd/mm/yyyy)	Time (24 hour)	IH Sponsor or Signatory Name / Signature	Initials	Designation

## INSTRUCTIONS FOR COMPLETING FORM

**Applicant's Name** – Print the first and last name of the person requiring access.

**Student** - Choose this box if you are a student

**Contractor/Consultant** - Choose this box if there is an end date specified in your contract.

**Agency** - Choose this box if there is no end date

**Volunteer** - Choose this box if you will be a Volunteer in an IH facility

**Renewal** - Choose this box if you are resubmitting an application for the same External Entity because you were requested to do so by Interior Health or to change personal information such as name, phone or PIN.

**Termination** - Choose this box to request access removal. Agency/Sponsor signature required. Applicant signature is not required.

**User ID** - Specify your existing or previous IH user ID if known.

**External Entity** – Print the name of the external entity to which the applicant is affiliated. e.g. educational institution, company, agency.

**Applicant's Position** – Print the position held or role performed by the applicant at the external entity, if applicable. For students, specify program, e.g. RN, LPN, Unit Clerk, Lab Tech, etc.

**IH Worksite and Department** – Print the worksite name and department where the applicant will access IH systems from. Please include department (e.g. Emerg, Peri, OR, MH)

**City** – Print the city in which the external entity of the applicant is located.

**Applicant Phone #** - Print the contact phone number for the applicant, including area code.

**IH Sponsor or Signatory Name** – Print the name of the IH sponsor or signatory of the external entity, as identified on the External Letter of Agreement (EALA). This person may be contacted if there are any issues with access.

**IH Sponsor or Signatory Phone #** - Print the contact phone number, or other individual representing the external entity's management of the applicant.

**IH Sponsor or Signatory Email** - Print IH sponsor or signatory's office email address. This is the email address that will be used annually to verify that this user is still on staff and still requires access.

**4 Digit Personal ID Number (PIN)** - Select a numeric ID you will remember such as your month & day of birth. For example: January 15 would be 0115 (ddmm). The Personal ID Number (PIN) is used to authenticate the applicant in the event the Service Desk is contacted to make changes to the applicants account such as a password reset.

**Date access required** – Print the requested start date of access in the format of dd/mm/yyyy (example: 19/09/2010).

- For students, this date should be the end date of their on-site practicum.
- For contractors/consultants this date should be no later than the termination date of their contract with IH.

### Is MEDITECH Required?

If yes, provide the name of a user with the same access required by this applicant (i.e. someone in a similar role)

- For students please enter the appropriate template or Job Role (MPA) name provided to you by the IH IMIT analyst. If not known, leave blank.
- For contractors/consultants, please contact your IH Sponsor to specify if and what type of Meditech access you will require.
- For entity staff, please provide the name of a user with the same access required. This information will be used to identify the proper template or Job Role (MPA) required for the applicant. If unsure, please inquire with your entity's IH contact person.

**Remote Access Required?** - Will the applicant require IH systems access from a non IHA site? (ie: external office). Select Yes or No. If yes, please specify what applications (software) or shared drive folder access is required.

### Business justification and list of applications/folders/required?

If yes, you must provide business justification and specific applications/folders to be access remotely.

**\*\*FOR STUDENTS & CONTRACTORS ONLY\*\*** Is OUTLOOK Required? – Select response by checking appropriate box.

- If Yes, why? (Provide a brief justification for requiring an IH Outlook account)

Read the remainder of the form (along with the referenced IH Policies) ensuring you follow the instruction noted:

"By checking () each statement, I indicate that I have read, understood and agree to abide by the following"

**Applicant Signature** – Signature of applicant.

**IH Sponsor / Signatory Signature** - This is the person authorizing access for the applicant.

**Date** - Print the date form signed by applicant in the format of dd/mm/yyyy (example: 17/04/2011).

To avoid processing delays, please ensure you have completed all sections prior to submitting the request. Access requests should be submitted at least 2 weeks PRIOR TO access being required.