Jefferson Health
HOME OF SIDNEY KIMMEL MEDICAL COLLEGE

Nursing Student Access Request

This form is used by medical students to request access to Kennedy Health System technology resources.

Instructions

*****PLEASE TYPE DIRECTLY INTO THIS FORM, THEN PRINT AND SIGN*** Signatures must be Handwritten, digital signatures will not be accepted. All fields are required. Fax completed forms to Kennedy Clinical Education & Research Department at (856)346-6328.**

TYPE OF REQUEST

☒ **Nursing Student**

CONTACT INFORMATION

LASTNAME	FIRSTNAME	MI	SCHOOL

TELEPHONE *(will be published in internal directory)*	E-MAIL ADDRESS *(for notification when accounts are created)*

EXPIRATION DATE	
	Access will be terminated on expiration date. If student is returning for a different semester a new form will be required to request access.

AVAILABLE SYSTEMS

Please check off the systems that you are requesting access to.

☒	**XenCore**	**Base access to Kennedy technology resources.**
☒	**Soarian**	**On-line viewing of inpatient/outpatient census, patient demographics, results, medical administration record and links to scanned charts and radiology images.**
☐	**EDIS**	**Read only access to Picis PulseCheck Emergency Department Information System. Copy from Intern-Non EM/Resident.**

APPROVAL

Nursing students must have authorization to obtain access to Kennedy technology resources. Approval must first be obtained from a representative of the Clinical Education and Research Department.

AUTHORIZED SIGNATURE	PRINT NAME	DATE

CONFIDENTIALITY STATEMENT

I understand and agree that the information/data I have been authorized to access is considered ***CONFIDENTIAL.*** Under **NO** circumstances will such information available to me be used, conveyed or discussed by me, unless required in the performance of my duties. I will adhere to all organizational policies that define the confidential information and the protection of that information at the Kennedy Health. Use of any computing resource at the Kennedy Health System including, but not limited to; wireless, PDA, Internet, company issued smart phone, or Remote Access is strictly for business purposes. System access will be tracked and monitored for proper use. Furthermore, I agree to the following:

a. I will not make any unauthorized copies of data, which includes photography, and will not save any confidential information to portable media devices (memory sticks, CDs, and other devices) unless;
b. I will not email data to another email account except as expressly provided for in the secure networking environment provided Jefferson Health;
c. **I ACKNOWLEDGE THAT MY AUTHENTICATION CODE AND PASSWORD IS THE LEGAL EQUIVALENT OF MY SIGNATURE. I AGREE THAT I WILL NOT DIVULGE, RELEASE OR SHARE MY AUTHENTICATION CODE OR DEVICE OR PASSWORD WITH ANY OTHER PERSON, INCLUDING ANY ASSOCIATE OR PERSON ACTING ON MY BEHALF, AND I SHALL NOT PERMIT ANYONE ELSE TO ACCESS ANY INFORMATION UNDER MY AUTHENTICATION CODE OR DEVICE OR PASSWORD, AND FURTHER AGREE NOT TO USE OR RELEASE ANYONE ELSE'S AUTHENTICATION CODE, DEVICE OR PASSWORD;**
d. **I acknowledge that I am responsible for all usage on my account and that my account may be monitored at any time;**
e. I agree to notify the Help Desk **IMMEDIATELY** if I become aware or suspect that another person has access to my authentication code, device or password or otherwise become aware of a potential or actual breach and/or if I have reason to believe that the confidentiality of my password is broken or believe that there has been a misuse of data;
f. I agree to lock or log out of my workstation before leaving my work area to prevent others from accessing confidential information;
g. **I agree to never retrieve, open, read, edit, or print data, including the PHI of my family members, friends or coworkers, celebrities, public figures, etc. unless the access is necessary to perform my job;**
h. **I am aware that any unauthorized access to, alteration or destruction of PHI will result in disciplinary action/termination.**
i. **I understand that the HIPAA Privacy Rule permits me to have access to my own record. I agree and understand that I can *only* access MY records through the approved sources (i.e.: Medical Records, Laboratory or Medical Imaging) using a HIPAA compliant authorization or via the patient portal. The use of my logon and password for the purpose of obtaining my own records will result in corrective action;**
j. I will not install or use illegal copies of software on corporate computers;
k. I will not text **ANY** data except as expressly provided for in the TigerText® smart phone application and consistent with the Secure Text Messaging Policy (Administrative Manual A313).

SIGNATURE	LAST 4-DIGITS OF SSN	DOB	HOME ZIP CODE	DATE