

**MultiCare Health System Intake Form**

*This form is to be completed after review of MultiCare Policies and must be completed and processed through the appropriate MHS Support Departments prior to client obtaining access to MultiCare systems.* **Return this form to** Kandreas@multicare.org

**Type of GME Learner:**

€ *Community Guest Resident NPI#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, DEA#\_\_\_\_\_\_\_\_\_\_\_\_\_ (military except)*

€ *ARNP Student* € *CNM Student* € *PA Student* € *Medical Student*

**MHS Sponsor Name: Kareena Andreas Sponsoring Department: GME**

**Has this individual ever:**

Has a background check been completed? \_\_\_\_ (must be completed)

Been employed by MultiCare Health System or Good Samaritan Community Healthcare?  \_\_\_\_

Volunteered for MHS or GSCH?  \_\_\_\_

Served in a non-employed staff capacity for MHS (i.e., former student/resident)? \_\_\_\_

Is this individual related to an MHS-employed physician?  \_\_\_\_

**User Information:**

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI: \_\_\_\_

Alias/Former Names: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Job Title/Role: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(MD, DO, or student)

Last 4 of Soc Sec #: ­ \_\_\_\_\_\_\_\_\_ Birthday (MM/DD): \_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Program Information:** School or Residency Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ TractManager # (GME office to fill out): \_\_\_\_\_\_\_\_\_\_\_\_\_School or Residency Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_School or Residency Coordinator Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Location Specific Department**[ ]  Allenmore [ ]  Auburn [ ]  Covington [ ]  Good Samaritan [ ]  MMA Clinic \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**[ ]  Mary Bridge [ ]  Tacoma General [ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| **System Access Management/Educator Information Section (to be filled out by MHS sponsor/educator)** |
| **Login ID (if existing user)** | **Start Date for Access****End Date for Access** | **Special set-up instructions for the IS&T department?** **Send acts to** **Kareena.Andreas@multicare.org** |
| X MultiCare Connect (Epic/Hyperspace) X Windows Log-On (MHS domain account)[ ]  MultiCare.Org E-mail Account X MultiCare Imaging PACs [ ]  Pyxis Medstation[ ]  Lawson[ ]  Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Remote access**[ ]  MyPortal (Citrix) website**Other Citrix Applications Needed**[ ]  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **IMPORTANT: Please explain your business needs for the above selected access types.** |

User Signature: Date:

Delegate Name *(if applicable)*: Initials:

MHS Sponsor Signature: *Kareena Andreas* Date Processed:

Licensed Entity (Company Manager Signature):

*Per MHS Policy “Records Management & Retention”, this information and all accompanying material must be kept on file with the sponsoring department for no less than ten (10) years after date of off-boarding for each client.*

Page |2 of

**MHS Confidentiality & Use Statement**

I understand that MultiCare Health System (“MHS”) Information Services (“IS”) provides a wide range of services and support to physicians and other healthcare providers, and their support staffs, within its service area, including the provision of practice management tools and access to electronic medical records and patient accounting systems.

I acknowledge that MHS maintains patient records and information in a confidential manner. Information in patient records or information collected from the patient is kept in strict confidence in accordance with the Uniform Health Care Information Act, the Health Insurance Portability & Accountability Act, and other state and federal laws. Systems for the privacy and security of patient records have been developed and are an important part of protecting patient confidentiality.

I have requested user identification and a password allowing me to access confidential patient records maintained by MHS within one or more Application(s) or System(s), for the purpose of supporting the Licensed Entity (LE) that has sponsored me as an End User., If granted privileges to access such information, I agree to abide by all MHS policies and procedures pertaining to access and use of MHS Application / System records. I understand such policies and procedures may change from time to time, and I agree to participate in appropriate Application / System user education and training on an ongoing basis, and to familiarize myself with all applicable MHS policies and procedures.

I have reviewed the MHS policies and procedures regarding patient confidentiality. As a condition of my access to and use of information maintained within MHS Application(s) / System(s), I agree to abide by all established MHS policies relating to patient confidentiality. I will not access patient records or information via hard copy or information system unless I have a “need to know” in order to perform my duties as an authorized End User sponsored by the Licensed Entity noted below..

I understand that entries in patient records within MHS Application(s) / System(s) are accessible by other health care providers, and once entered become part of the patient’s composite health record within MHS and cannot be removed or segregated from other records within MHS applicable to such individual patients, particularly with regard to any MHS Patient Care Information System(s).

I understand that unauthorized use or disclosure of patient information may subject me to civil liability under state and/or federal law, and that improper disclosure may also constitute a crime. I understand and authorize MHS to monitor and audit my use and access of all MHS Application(s) / System(s).

I agree to use and access protected health information strictly for lawful purposes within the scope of my duties and responsibilities and for no other purpose. I accept responsibility for taking appropriate measures to secure my workstation. I also agree to keep my MHS Network System password(s) private and not share password(s) with others.

I assure MHS that I will not, under any circumstances, use or disclose patient information for any unauthorized purpose, and I will take appropriate steps to protect the confidentiality of patient information and records.

I will immediately report to the MHS Information Services Help Desk any observed or known violations of this user agreement by myself or others having access to MHS Applications or Systems.

I understand that unauthorized use or disclosure of patient information constitutes a violation of my employment or my sponsoring Licensed Entity’s agreement with MHS allowing access to MHS Application(s) or System(s), and that willful violation of MHS rules may result in termination of my access or my sponsoring Licensed Entity’s rights to utilize MHS Application(s) or System(s).

I have read and understand the above statements.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sponsoring Licensed Entity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name (please print)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Witness Name (Please Print)

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Date Witness Signature