Froedtert Hospital

REQUEST FOR ID BADGE

APPLYING FOR: X ID / ACCESS CARD ___ID CARD ONLY ___ACCESS CHANGE
* NEEDS OTOLARYNGOLOGY MEDICAL STUDENT ACCESS

PRINT ALL INFORMATION

Cell #____________________

Name: ______________________________

PH/Ext NA

Dept. / Unit: Otolaryngology

Start Date:______________

Title: Visiting Medical Student

Employee #: NA

Employed By: ☐ FROEDTERT ☐ MCW ☐ VOLUNTEER

☒ STUDENT ☐ OTHER______________

Status: ☒ SFT ☐ SPT ☐ OPT ☐ TEMP ☐ FLOAT

Shift: ☒ FIRST ☐ SECOND ☐ THIRD ☐ ROT

Vehicle Info- 1) Make: ______________ 2) Make: ______________

Model: ______________ Model: ______________

Plate: ______________ Plate: ______________

State: ______________ State: ______________

I understand that I am required to pay a $5 (non-Refundable) fee before I receive my ID/access card. I futher understand that I must return the card to Security in person when no longer working at Froedtert. I also understand that if I lose or damage this card, I am required to replace this card and pay an additional $20.00 (non-refundable) before a replacement card will be issued. I further understand that parking in areas other than my assigned location may result in the issuance of a parking ticket.

______________________________ ______________________________

Signature **Date**

FOR OFFICE USE ONLY

Parking assigned to: ☐ West Structure ☐ West Surface ☐ Physician

☐ East Structure ☐ East Surface ☐ State Fair

Card Number:____________________ Payment Amount:__________ Type:________

Access Group should mirror what staff member______________________________

Manager Signature______________________________

FROEDTERT HEALTH **CONFIDENTIALITY & ELECTRONIC SECURITY AGREEMENT**

RELATIONSHIP TO FROEDTERT HEALTH:		
☐ FROEDTERT HEALTH STAFF MEMBER	☐ VOLUNTEER	☐ TEMPORARY EMPLOYEE
☐ FROEDTERT HEALTH STUDENT	☐ MEDICAL STAFF	☐ RESIDENTS
☒ MCW STUDENT: Visiting Student	☐ MCW STAFF:	☐ OTHER:

DEMOGRAPHIC INFORMATION: (*PLEASE PRINT CLEARLY*)	
FIRST NAME:	**LAST** NAME:
FH EMPLOYEE ID#:	JOB TITLE:
DEPARTMENT:	ENTITY LOCATION:

GENERAL CONFIDENTIALITY REQUIRED BY ALL:

As a condition of my use, access, and/or disclosure of confidential Froedtert Health or any Froedtert Health Affiliate (collectively FH) information, I understand that I am responsible for my actions and agree to protect and secure confidential information and will abide by the requirements set forth in this Agreement. I understand that the obligations under this Agreement will continue even after my employment or business relationship has ended with FH. I agree to the following:

1. I will protect and secure confidential information. Confidential information includes patient information, workforce information and/or any business related information that is not publicly available.
2. I will only access, use, disclose, copy, review, alter, remove or destroy confidential information as authorized to carry out approved and legitimate job functions, and in accordance with applicable policies and procedures and State and Federal regulations.
3. I will not access, use and/or disclose my own Protected Health Information (PHI) or the PHI of my family, friends, co-workers, neighbors, media story patients or any other patients for personal reasons or for any other non-job duty related purpose. (Examples of PHI include: all patient information medical record information, appointment date/time, demographics, billing, room number, etc.)
4. I understand that if I or my family members need information about an appointment, care or services with any FH Affiliate, the approved process is to obtain this information from the provider, MyChart, or to request information from the Health Information Management Department.
5. I will exercise extreme caution when discussing confidential information to prevent others from overhearing and will do so only when there is a legitimate business need. I agree not to gossip or talk inappropriately about patients.
6. I will prevent accidental release of confidential information by validating patient identifiers (name, DOB, address) and double checking my work to assure I have the correct information prior to disseminating confidential information. I will also be careful not to leave confidential information in unsecure areas such as conference room, restroom, cafeteria, etc.
7. I understand and agree that I have no individual rights to, or ownership of any information accessed or created by me during my relationship with FH.
8. I will immediately report to the FH Corporate Compliance Department, any actions or activities that I suspect may compromise the confidentiality of patient, workforce or other confidential business information.

CONFIDENTIALITY REQUIREMENTS FOR THOSE WITH ELECTRONIC ACCESS:

I understand that my userid/password is my personal access code for my electronic system access. It acts as my personal signature when performing electronic activities, and I agree to the following:

1. I will follow the FH Information Technology (IT) security policies and will only access or use systems or devices, including portable devices and USB media that I am properly authorized to use and will do so in the appropriate manner identified.
2. I will keep my userid/passwords secure and will not disclose them to anyone or allow others to use my workstation when I am logged in. I will not request access to any other person's passwords or access codes nor will I will use a workstation that is logged in under someone else's unique access code.
3. I will secure the computer workstation when it is left unattended and I accept responsibility for all activities under my access code. If the security of my access codes has been compromised, I will immediately change my password and report it to the FH IT Department.
4. I will keep mobile devices password protected and will take precautions to keep the device from being lost or stolen.
5. I will not make any unauthorized transmissions, inquiries, modifications or purging of confidential information. I will not modify the workstation configuration or use or add software to it without prior authorization from the FH IT Department.
6. I understand that FH has the right to maintain system audit trails and that it may conduct audits at any time and without notice, of any use, activity or access by me within the IT environment, or within any FH facility.
7. I understand that FH may revoke my userids/passwords at any time.

By signing this document, I agree with the terms and I understand that violation of any part of this agreement may result in corrective action, including termination of employment or business relationship with Froedtert Health. Additionally, certain violations may be subject to external agency enforcement. (e.g. State Licensing Boards, Law Enforcement, or civil and/or criminal penalties.)

Signature Date