OneChart/Clinical Connect System Access Request Application St. Thomas Elgin General Hospital

Legal Name: _____ _____ _____ Request Date _____ Account Expiry: _____
Last Given referred Name (dd/mm/yy) dd/mm/yy)

Position/Job Title: _____ Dept/Prog/Location: _____

Phone No: 519 **631 2030** Ext: _____ Email:_____ Day/Month of Birth: dd ____ mm_____

Describe your relationship to the hospital:

☐Physician with privileges: _____ OHIP Billing # _____ CPSO# _____

☐ Employee of hospital: Employee ID # (from pay stub): _____ College Registration # _____

☐ 3rd party employee: Name of employer/agency:_____ Driver's license #_____

☐ Student: Area of Study/School:_____ Student ID #_:_____

☐ Other specify_____ Driver's license #_____

If applicant is a student or 3rd party employee indicate dd/mm/yy this individual is expected to leave_____

Are you employed by or currently have privileges at another hospital? ☐ No ☐ Yes
List hospitals: _____ Do you have a login account at any of these hospitals? Yes ☐ No ☐

Reason for request: ☐ Clinical Care ☐ Research ☐ 3rd party work ☐ Other:_____

Authorizing Information
The information submitted on this System Access Request Form is accurate and complete and that the applicant requires access as requested to perform his/her functions and duties at this hospital.
St. Thomas Elgin General Hospital Local Registration Authority Clinical Informatics/Information Technology
519-631-2030 Ext. 2400 Email: helpdesk@stegh.on.ca

Access Agreement and Obligations

This information summarizes your obligations when using the STEGH/LHSC/OneChart/Clinical Connect computer network, and its information systems and data. Failure to comply with these obligations may lead to the discontinuation of your network privileges. It is the responsibility of Information Management to monitor and enforce the conditions of this agreement. Any inappropriate use of the network may also result in disciplinary action up to and including termination/loss of privileges.
Accessing, modifying, deleting, copying, printing, disclosing, restricting access, or otherwise tampering with files and/or data to which you have not been given authorization to access. Electronic patient records may be accessed only if there is a direct patient care or approved research relationship with patient consent.
You will be assigned a unique identifier and a confidential password to access the appropriate systems for which you have approval. It is your responsibility to maintain the confidentiality of that password. The hospital systems maintain an internal record of all transactions carried out by you through the use of your password. This internal record of your activity may be audited as part of the hospital's security management practices. You are responsible and accountable for all transactions associated with your password.
If, at any time, you suspect that the confidentiality of your password has been compromised, you should immediately change your password and inform your direct supervisor as well as Information Services.
Any patient-related information accessed through the hospital systems is strictly confidential and should be used only in the performance of necessary duties and in accordance with hospital policy. Individuals accessing electronic patient records for research purposes must document the reason for access in the comments section of the electronic patient record.

I have read; understand and agree to abide by the responsibilities outlined in this document:

Applicant's Full Name: _____ Signature _____

Position/Job Title: _____ Date (dd/mm/yy) _____

CONFIDENTIALITY AGREEMENT
St. Thomas Elgin General Hospital

All residents/patients/clients under the care of St. Thomas Elgin General Hospital and all staff/hospital affiliates/other affiliates have a fundamental right to have their health/medical/personal information treated in confidence.

This statement confirms that I have read and understand the Confidentiality Policy for St. Thomas Elgin General Hospital.

I commit to hold in confidence all the information about patients, residents, clients, and their families, staff /hospital affiliates/other affiliates of the hospital, as well as the confidential business information of the hospital, which comes to my attention while carrying out my duties as agreed within the hospital.

I commit to continue to respect and maintain the confidentiality of patients, residents, clients and their families, and hospital staff/hospital affiliates/other affiliates, as well as the confidential business information of the hospital even after my employment/affiliation with the hospital ends.

I understand that I may consult my Manager/Professional Practice Leader/Human Resources/Risk Management, or the Privacy Officer for details regarding this and related policies.

I understand that misuse, failure to safeguard, or the disclosure of confidential information without appropriate approvals may be cause for disciplinary action up to and including termination of employment/contract or loss of appointment or affiliation with St. Thomas Elgin General Hospital.

I have completed the:

- ☐ Professional
- ☐ Regulated health Professional
- ☐ Clinical Support
- ☐ Non-Clinical Support
- ☐ Not Applicable
- ☐ Module of Privacy and Confidentiality education program

Please check one:

- ☐ Employee
- ☐ Physician
- ☐ Volunteer
- ☐ Non-Clinical Support

Printed Full Name:	
Area of Service/Department:	
Signature:	
Date: (yyyy/mm/dd)	