

DESCRIPTION OF SYSTEM

IntelliDose is an electronic system that automates chemotherapy order-writing and chemotherapy nursing documentation.

THIS INFORMATION IS TO BE FURNISHED BY THE APPLICANT (PLEASE PRINT LEGIBLY)

- Please complete ALL sections on ALL pages of this form (Incomplete forms will not be processed).
- The applicant must sign the **yellow** section (**SECTION A**) of page 2. The supervisor must sign the **green** section (**SECTION B**) of page 2.

NEW USER ACCESS (Specify Start Date: _____)

MODIFY USER ACCESS

APPLICANT'S INFORMATION

FIRST NAME	M.I.	LAST NAME	PHONE NUMBER (WITH AREA CODE)
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REQUIRED *FIELDS*	C# *REQUIRED* (IF NO C#, MUST INCLUDE DATE OF BIRTH)	DATE OF BIRTH (IF NO C# IS PROVIDED, MUST INCLUDE DATE OF BIRTH)
	MEDICAL USER NAME (EMAIL) *REQUIRED*	

POSITION TITLE	ORGANIZATION NAME (e.g., ABLEH, UMH, UMHC, UMMG, OTHER)
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LOCATION BUILDING	DEPARTMENT	DIVISION
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ROLE/FUNCTIONAL ACCESS REQUIRED

RN PHARMACY NURSING AND PHARMACY ADMINISTRATION (REPORTS)

INQUIRY ONLY (Functional Roles: Administrative Assistants, Coding, Financial Representatives, etc.)

RESEARCH (Functional Roles: Investigators and/or Coordinators who are contributing to the scientific development or execution of a protocol)

Accessing this system for the purpose of research requires that the requestor notify the CET department once his/her CITI certification expires.

UMCET ANALYST

HIPAA (Privacy & Security of Protected Health Information)

The University of Miami has developed policies and procedures for the use and disclosure of University patient health information in compliance with applicable state and federal laws, including the **Privacy & Security** standards promulgated under the **Health Insurance Portability and Accountability Act of 1996 (HIPAA)**. By signing this form you hereby agree to comply with HIPAA. Furthermore, by signing this form, you affirm the fact that you've taken and successfully passed the 'HIPAA Privacy & Security Awareness' online training. If you have any questions concerning our policies and procedures, please contact the Office of Privacy and Security at **305-243-5000**, email us at hipaaprivacy@med.miami.edu, or visit our site: <http://med.miami.edu/hipaa>.

SECURITY ADMINISTRATION PROCEDURES

1. Complete the required information on this EHR Access Request Form
2. Return the completed form to the Clinical Enterprise Technologies department. The form can be faxed to 305-243-7355. Training Registration is not complete until the form is received with the appropriate signatures.
3. The completed form will be submitted to the appropriate Departmental Representatives for approval.
4. Username and password will be assigned & send via email once the request is approved and the training has been completed.

If you need assistance, please contact the CET Support Desk at 305-243-7339.

APPLICANT'S SIGNATURE

SECTION A By signing this access request form, I understand and agree to maintain the confidentiality of patient health information and will refer all requests for disclosures to the Health Care Provider Medical Records Custodian or the hospitals' HIM departments. Furthermore, I understand that I will receive a unique username and password that is not to be shared and/or made public and will sign off the system before leaving the workstation. In addition, I understand that if I don't access the system for over 3 months, my account will be deactivated. **For the sole purpose of research, I understand that I must notify the CET department once my CITI certification expires, at which point, access to the IntelliDose system will be revoked. Access will be granted once my CITI certification is renewed.**

APPLICANT'S SIGNATURE	APPLICANT'S PRINTED NAME	DATE
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APPLICANT'S UM SUPERVISOR, AUTHORIZING MANAGER, SPONSOR/LIASON OR ADMINISTRATOR

SECTION B By signing this access request form, I acknowledge and confirm that the above applicant needs access to the system referred to in this application in order to perform his/her job functions. I will notify the CET department upon this employee's termination and/or transfer to a different position or department where access must be assessed as it relates to their job functions by their new supervisor. **Furthermore, if access is granted for the sole purpose of research, I understand that the employee's CITI certification must first be confirmed as current prior to authorizing access. In addition, I will notify the CET department upon this employee's expiration of his/her CITI certification. Access to the system will be granted once the CITI certification has been renewed.**

SUPERVISOR'S SIGNATURE	SUPERVISOR'S PRINTED NAME	SUPERVISOR'S PHONE #	DATE
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