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# MultiCare Health System Intake Form

MultiCare BetterConnected

*This form is to be completed after review of MultiCare Policies and must be completed and processed through the appropriate MHS Sponsoring Departments prior to user obtaining access to MultiCare systems.*

☐ *Agency/Clinical Per Diem* ☐ *Agency/Clinical Traveler* ☐ *Agency/Non-Clinical Temp* ☐ *CareConnect*
☐ *Community Provider* ☐ *Consultant* ☐ *Contractor* ☐ *Resident* ☑ *Student* ☐ *Volunteer*

**Has this User ever: (Answer yes or no)**

Had a background check completed? _____
Been employed by MultiCare Health System? _____
Volunteered for MultiCare Health System? _____
Served in a Non-Employed staff capacity for MultiCare Health System? _____

**User Information:**

Last Name:_____ Legal First Name:_____ MI:_____
Former Names:_____ Job Title/Role:Student
Students: List Program_____
Last 4 of Soc Sec #:_____ Birthday (MM/DD) Only:_____
Personal Address: _____
City:_____ State:_____ Zip Code:_____
Phone:_____ Work Phone:_____ Email:_____

Please fill out the following information as it pertains to your **Agency / Company / Licensed Entity / School**:

Name: Spokane Community College / Invasive Cardiovascular Technology Program
Address: 1810 North Greene St
City: Spokane State: WA Zip: 98217
Manager /P.O.C. Name: W. Scott Corson P.O.C. Email: wscorson@multicare.org
Point-of-Contact Phone: 253.403.33438 Point-of-Contact Fax: 253.403.3491

**Location:**

☐ Allenmore Hospital ☑ Auburn Medical Center ☐ Covington Medical Center ☐ Gig Harbor Medical Park
☑ Good Samaritan Hospital ☐ Mary Bridge Children's Hospital ☑ Tacoma General Hospital
☐ Clinic: _____
☐ Other:_____
**Specific Department/Unit:** Cardiac Cath Lab / IR

MHS Sponsor Name: Jolita Perez
Sponsor Email: jolita.perez@multicare.org @multicare.org
Sponsor Phone: 253.403.5348

User Signature: _____ Date: _____

**You may Fax completed forms to one of the following:**

For Non-Employed Staff: (253) 864-4011 For Community Providers: (253) 864-4012
For Imaging Administration: (253) 864-3912

## MHS Confidentiality and 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.

During the normal course of my duties at MHS, I may have access to confidential patient records, protected health information (PHI), Personally Identifiable Information (PII), sensitive business information and other types of information that must be kept in confidence by me. This information may be maintained by MHS within one or more Application(s) or System(s), for the purpose of providing treatment to my patients, business operations and other reasonable business practices. By having access to 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 and information security. 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 provide medical care and treatment to my patients.

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 PHI, PII or other sensitive 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 PHI, PII and other sensitive 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 PHI, PII or other sensitive 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 PHI, PII or other sensitive information constitutes a violation of my employment or my clinic's or department'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 clinic's or department's rights to utilize MHS Application(s) or System(s).

I have read and understand the above statements.

_____
User Name (Please Print)

_____
User Signature

_____
Date

W. Scott Corson
_____
Witness Name (Please Print)

_____
Witness Signature

☑ By typing your name and date on the indicated signature lines, you agree that it constitutes your Electronic Signature and is the equivalent, and has the same force and effect of your handwritten signature. Check the box to indicate you agree.

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## System Access Please contact your Sponsor for any IS access that will be needed and indicate below:

| Login ID (if existing user): | Start Date for Access: | Special set-up instructions? |
|---|---|---|
| | Sep. 19, 20<br>**End Date for Access:**<br>Jun. 20, 202 | Please make share drive available on desktop if possible |
| **System Access:**<br>☐ MultiCare Connect (Epic/Hyperspace)<br>☑ Windows Log-On (MHS domain account)<br>☑ MultiCare.Org E-mail Account<br>☐ MultiCare Imaging PACs<br>☐ MultiCare Link (Epic/Read-Only)<br>☐ Lawson | **Other System Access Needed: (i.e. shared drive)**<br>☑ Please provide READ ONLY access<br>☐ to the ict share drive at<br>\\mhsusera\ict | **Remote access:**<br>☐ MyPortal (Citrix) website<br>**Other Citrix Applications Needed**<br>☐ _____<br>☐ _____ |
| **IMPORTANT - Please explain your business need(s) for the above selected access type(s):** | | |

Agency/Company/Licensed Entity/School (Signature):_____

☑ By typing your name on the indicated signature line, you agree that it constitutes your Electronic Signature and is the equivalent, and has the same force and effect of your handwritten signature. Check the box to indicate you agree.

*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.*