

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 Sponsoring Department prior to user obtaining access to MultiCare systems.

- Agency/Clinical Temp
 Agency/Non-Clinical Temp
 CareConnect
 Credentialed Provider (MHS Privileges)
 Consultant
 Contractor
 Daily Agency/Per Diem
 MultiCare Link
 Resident
 Student
 Traveler
 Vendor
 Volunteer
 Other: _____

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: _____
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: _____	
Address: _____	
City: _____	State: _____ Zip: _____
Manager /P.O.C. Name: _____	P.O.C. Email: _____
Point-of-Contact Phone: _____	Point-of-Contact Fax: _____

Location:	
<input type="checkbox"/> Allenmore Hospital <input type="checkbox"/> Auburn Medical Center <input type="checkbox"/> Covington Medical Center <input type="checkbox"/> Deaconess Hospital <input type="checkbox"/> Good Samaritan Hospital <input type="checkbox"/> Immediate Clinic <input type="checkbox"/> Indigo Urgent Care <input type="checkbox"/> Mary Bridge Children’s Hospital <input type="checkbox"/> Rockwood Clinic <input type="checkbox"/> Spokane Internal Medicine <input type="checkbox"/> Tacoma General Hospital <input type="checkbox"/> Valley Hospital <input type="checkbox"/> Clinic: _____ <input type="checkbox"/> Other: _____	
Specific Department/Unit: _____	

MHS Sponsor Name: _____
Sponsor Email: _____@multicare.org
Sponsor Phone: _____

User Signature: _____ **Date:** _____

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 accountings 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

 Witness Name (Please Print)

 Witness Signature

Electronic-Signature Only: By providing my e-signature, I understand that checking this box constitutes my legal signature confirming that I acknowledge and warrant the truthfulness of the information provided in this document and is the equivalent and has the same force and effect of my wet (handwritten) signature.

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

<p>System Access:</p> <p><input type="checkbox"/> No System Access Needed</p> <p><input type="checkbox"/> E-Mail Account *Cost Center will be charged</p> <p><input type="checkbox"/> EPIC – Full Access (Role Based)</p> <p><input type="checkbox"/> EPIC – Read-Only</p> <p>MyPortal - myportal.multicare.org</p> <p><input type="checkbox"/> Imaging PACs</p> <p><input type="checkbox"/> MultiCareLink (EPIC – View-Only)</p> <p>Link Portal - link.multicare.org</p> <p><input type="checkbox"/> Windows Log-On (MHS username/password)</p> <p>*required for personnel needing access</p>	<p>Special set-up instructions? Please list them here: (Example: Please set-up access like Jane Doe, please mirror to John Doe, Please set-up Epic In-Basket, etc.)</p> <hr/> <hr/> <hr/> <hr/> <p>Login ID (if existing user):</p> <hr/>
<p>Remote access:</p> <p><input type="checkbox"/> MyPortal (Citrix) website</p> <p>Other Citrix Applications Needed</p> <p><input type="checkbox"/> _____</p> <p><input type="checkbox"/> _____</p>	<p>Other System Access Needed: (i.e. shared drive (please provide the path), SunQuest, Unix, etc.)</p> <p><input type="checkbox"/> _____</p> <p><input type="checkbox"/> _____</p> <p><input type="checkbox"/> _____</p>
<p>IMPORTANT - Please explain your business need(s) for the above selected access type(s):</p> <hr/> <hr/>	

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

*MHS Sponsor is responsible for requesting the appropriate access for the user!!!

Electronic-Signature Only: By providing my e-signature, I understand that checking this box constitutes my legal signature confirming that I acknowledge and warrant the truthfulness of the information provided in this document and is the equivalent and has the same force and effect of my wet (handwritten) signature.

Return Instructions:

- **Credentialed Providers (Puget Sound Region)** – please fax or email this form back to (253) 403-4870 or Credentialing@MultiCare.Org
- **Inland Northwest Region** – please email this form back to the appropriate email address:
For INW Students: INWStudents@MultiCare.Org; For Non-Credentialed Providers & all others: INWNonEmployee@MultiCare.Org
- **Puget Sound Region** – please fax or email this form back to: (253) 864-4011 or MultiCareNonEmployee@MultiCare.Org

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.