MultiCare

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:

☐ Allenmore Hospital ☐ Auburn Medical Center ☐ Covington Medical Center ☐ Deaconess Hospital
☐ Good Samaritan Hospital ☐ Immediate Clinic ☐ Indigo Urgent Care ☐ Mary Bridge Children's Hospital
☐ Rockwood Clinic ☐ Spokane Internal Medicine ☐ Tacoma General Hospital ☐ Valley Hospital
☐ Clinic:____
☐ Other:____
Specific Department/Unit: ____

MHS Sponsor Name: ____
Sponsor Email: ____________________________________@multicare.org
Sponsor Phone: ____________________________________

User Signature:______________________________________ Date: _____________

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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	______________________________________ Witness Name (Please Print)
______________________________________ Date	______________________________________ 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.

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

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

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.