Olive View-UCLA Medical Center

Information Systems User Registration Form

Type of Request	☐ ADD USER	☐ UPDATE ACCOUNT	☐ DELETE USER	☐ TRANSFER ➡ FROM: ________ TO: ________

LAST NAME (PLEASE PRINT)

FIRST NAME (PLEASE PRINT) M.I.

☐ COUNTY EMPLOYEE (6 digits) ➡ e

☒ NON-COUNTY EMPLOYEE (6 digits) ➡ c

RESIDENT	SURGERY	6D124	3194
JOB TITLE	DEPARTMENT NAME	WORK LOCATION NAME / ROOM NUMBER	PHONE NUMBER

ROBERT BENNION	3194	JUDY	JUDY
NAME OF SUPERVISOR	SUPERVISOR PHONE #	TRAINED BY	PERSON TO BE CONTACTED

Affinity RCO ☐

Affinity Legacy ☑

SAME MENU AS USER: ________

ESS	PYXIS	Synapse
☐	☐	☑

Quantim ☑

SAME MENU AS USER: ________

Domain Windows	E-mail Outlook	Internet
☑	☐	☑

REQUIRED *AFFINITY LEGACY* SECURITY QUESTIONS:

WHAT IS YOUR FAVORITE COLOR? ________ WHAT IS YOUR MONTH/DAY? MONTH: ________ DAY: ________

JUSTIFICATION: PATIENT CARE

Employee Acknowledgement of Data Security Responsibilities

It is the policy of Los Angeles County that all employees of Valley Care/ Olive View-UCLA Medical Center, whether they are permanent, temporary, part-time, contract, or any other, are personally responsible for the protection of all County information and information processing resources they have access to while employed by the Medical Center.

I understand that my responsibilities include the following:

- I will keep confidential all data pertaining to patient information. Printouts from the Hospital Information System, which contain identifying patient information, shall be considered part of the medical record and treated accordingly.
- I will use County data and computing resources for County management approved purposes only.
- I will protect and not share my Password and/ or User Code and other system access keys entrusted to me to do my job.
- I will log off before leaving a workstation and will not leave unattended any workstation I am using.
- I will comply with all software licensing and copyright agreements.
- I understand that by accessing the Internet via County owned systems and/or by using a County issued Internet address, such access shall be restricted to the conduct of legitimate County business. Use of the County provided Internet access for any other purpose would be subject to suspension of employee's network privileges and appropriate disciplinary action, including possible dismissal.

I hereby acknowledge that I will be held accountable for my deliberate or negligent actions that compromise the privacy, integrity, and availability of County data. Failure to comply with these directions is grounds for disciplinary actions.

USER SIGNATURE: DATE

E-MAIL ADDRESS (REQUIRED FOR INTERNET)

SUPERVISOR SIGNATURE: [signature] DATE

CHIEF INFORMATION OFFICER SIGNATURE: (REQUIRED FOR ALL INTERNET ACCOUNTS) DATE

Return completed forms to:
Information Systems – 1D132
or Fax to: (818) 364-3880

Form#: OVISFORM-00
Revised - 05/06/2016

COUNTY OF LOS ANGELES – VALLEYCARE
OLIVE VIEW – UCLA MEDICAL CENTER

SIGNATURE/ELECTRONIC APPROVAL
AUTHORIZATION FORM

Use this form to request authorization to electronically sign documents. This form also authorizes individuals to view, enter, update or disseminate electronic data only as required in the course of hospital business.. Individuals are authorized to certify and approve electronic transactions only when given the authority through the signature/electronic authorization form. This form formally delegates and authorizes use of electronic signatures to authorized individuals. Individuals cannot be delegated authority to certify or approve documents for another employee.

Provide all requested information and sign document.

Last Name__________________ First Name __________________ Middle Initial _____

Title Resident Employee# or SS#______________

Phone # 818-364-3194 Dept. Surgery

Signatures:______________________________________

I understand the signature/electronic authority and related responsibility delegated to me.
I agree that I am the only individual using/possessing the signature code, and I agree not to share the code with anyone. I agree that I will not access information other than the information that I am authorized to access and need to know in order to fulfill my responsibilities.

Approvals:

____
Supervisor Date

____
Signature of Person Being Authorized Date

I have received Hospital Information Systems Training.

______________________________ ______________

Employee Signature Date

______________________________ ______________

Division Head Signature Date

Health Services
LOS ANGELES COUNTY

PRIVACY & SECURITY SURVIVAL TRAINING: PROTECTING PATIENT INFORMATION

ANSWER SHEET AND PROOF OF COMPLETION

Instructions: Please circle the correct letter corresponding with the questions in the study guide. You must score 20 correct to receive credit for Mandatory Training.

1.	A	B	(C)	D	E	11.	A	(B)	C	D	E
2.	(A)	B	C	D	E	12.	A	(B)	C	D	E
3.	A	B	C	(D)	E	13.	(A)	B	C	D	E
4.	A	(B)	C	D	E	14.	(A)	B	C	D	E
5.	A	(B)	C	D	E	15.	A	B	C	D	(E)
6.	A	(B)	C	D	E	16.	(A)	B	C	D	E
7.	(A)	B	C	D	E	17.	(A)	B	C	D	E
8.	A	B	C	(D)	E	18.	A	(B)	C	D	E
9.	A	B	(C)	D	E	19.	A	B	C	(D)	E
10.	A	(B)	C	D	E	20.	A	(B)	C	D	E

PLEASE PRINT LEGIBLY

LAST NAME		FIRST, MIDDLE NAME		EMPLOYEE/ID NO.
JOB CLASSIFICATION Resident	ITEM NO	DEPT/DIVISION Surgery		P/L 92
WORKFORCE MEMBER SIGNATURE				DATE
☐ Check here if non-DHS/non-County Workforce Member	SCHOOL/EMPLOYER NAME UCLA			PHONE NO.

I attest I have read the Privacy & Security Survival Training: Protecting Patient Information Study Guide and am familiar with the contents and will abide by the guidelines set forth.

If I have any questions or concerns, I will talk to my supervisor or the facility Privacy or Information Security Coordinator.

SUPERVISOR/MANAGER NAME (PRINT)	SUPERVISOR/MANAGER SIGNATURE	DATE
ROBERT BENNION, MD	[signature]	

Distribution: Original - Area File Copy - Facility Human Resources

PROVIDER ORIENTATION ATTESTATION

I acknowledge that the following information is available for my review and understanding of the DHS Provider agreements with Managed Care Health Plans:

- Health Plan's Provider Manual
- Health Plan's Member Handbooks
- Health Plan's Operations Manual

I understand that if I have any questions or concerns, I will talk to my manager for clarification.

Date: _________________

____
Print Providers Name (First, MI, Last)

____
Signature

Employment Start Date: __________________

Employee/Contractor #: __________________