ehc APPLICATIONS ACCESS FORM

- **Please fill out the applicant information at the top except for the shaded areas.**

HCA

FAX TO (843) 847- 4669

SSL Application Form

OVERVIEW

HCA Information Technology and Services and its ehc Internet division have developed Web based applications to give associated physicians and their staffs appropriate access to healthcare information. This access is to accommodate the relationship between the physician's practice and the associated hospital to provide patients required healthcare services.

These Internet based applications must maintain government-mandated levels of data protection, so certain security tools must be used to provide for strong authentication and data encryption to ensure the confidentiality of the patients' medical records.

You will be notified of incomplete forms, causing delay in the process of issuing cards and shipping software and you will be required to resubmit your request.

APPLICANT INFORMATION

User Responsibility Statement - Your remote access security PIN is not to be revealed to anyone (manager, co-worker, etc.). The information obtained through the use of your ID is to be used for work related activities only. The revealing of your PIN or information obtained through its use may result in oral/written warning, censor, suspension without pay, or termination. Your SecurID Card is a delicate piece of equipment and must be treated with care. In case of a lost card, contact IT&S Security **immediately**.

Last Name	First Name	MI

Telephone Number (with extension)	Practice Name	Birthdate

I would like access to: ☐ **Meditech via internet** ☐ **PACS**

Signature	Date	Social Security Number

********* DO NOT FILL IN BELOW THIS LINE *********

CLINICAL IMAGING SYSTEMS ADMINISTRATOR/SYSTEM ADMINISTRATOR

Approving Authority Responsibility Statement – By signing below I certify that I have reviewed this form for accuracy, that all preceding fields are completed, and that the applicant is a valid employee, contractor, physician or vendor requiring remote access. In addition I understand that any additional software required for remote access will be charged to my department. Furthermore, I agree to collect any SecurID Cards from holders upon their departure.

Printed Name	ARE YOU?	Department Number
	☐ Clinical Imaging System ☐ System Administrator ☐ Physician Support Coordinator	908

Signature	Date

Secure ID Number	Secure Access Card Expiration Date

LOCAL SECURITY COORDINATOR

Printed Name	Telephone Number	Applicant 3-4 ID
Judy B. Riley	(843) 797- 4109	

Signature	Date