oneChart (Cerner) Access Request: Allied Health Caregiver (AHC)

Purpose: This form is a **requirement** to be trained on Methodist Informations systems (oneChart) and receive access. Please go to **www.methodistmd.org** and click on "oneChart Training Schedule" in the Quick Action Links Section to view the schedule of **required training** for Allied Health Caregivers.

Please return completed form to OR, Inc. Training on system use is mandatory prior to account activation.

Legal Name (Last, First, MI)_____ Phone # ____/_____-_____
(Please Print)

Pager/Cellular #_____/_____-_____

Last 4 digits of Social Security #_____ Birth Month _____ Birth Day _____

E-mail Address _____

Primary Methodist Hospital(s) _____

Practice Affiliation/Name of Practice Group _____

Address _____Suite/Office #_____

City/State/Zip _____ Practice Phone # ____/_____-_____

Fax # for Medical Information _____ Fax # for AHC Communication _____

Please provide a secret question and answer the Information Systems Help Desk can use to identify you over the phone. The answer should only be known to you.

Identifying Question _____

Response _____

Confidentiality Agreement:

You are authorized to access and utilize certain data and information only for your patients and authorized consults. Each time you access a patient's records, your entry will be identified with you and permanently recorded. By affixing your signature below, you agree to follow any and all applicable policies and procedures implemented by Methodist Healthcare regarding the privacy and security of protected health information as that term is defined in 45 C.F.R. Parts 160 and 164. You also agree to take responsibility for the confidentiality of your passwords to gain access to such information. You also agree to comply and shall require all of your employees and Business Associates to comply, with all applicable federal and state laws, rules and regulations, including, but not limited to, the Health Insurance and Portability and Accountability Act of 1996 ("HIPAA") regarding the privacy and security of such information.

User's Name _____ Signature _____ Date ___/___/___
(Please Print)

Sponsoring LIP _____ Signature _____ Date ____/___/___
(**REQUIRED**) (Please Print)

OR, Inc. Use Only

1.Methodist ID # for AHC _____

2. Type of AHC:

☐ Clinical Research Assistant (non-licensed – Physician supervised)

☐ RN Clinical Research Assistant (Physician supervised) ☐ LPN Rounding Nurse ☐ RN Rounding Nurse

☐ Rounding Medical Assistant ☐ Ultrasound Technician ☐ Pathology Assistant ☐ Scribe

3. If this is a request to change information, please note the changes here _____

_____

By signature below, I hereby certify that the above named user has met the qualifications and required preliminary competencies outlined in the Agreement between Methodist Healthcare - Memphis Hospital and OR Nurses, Inc. dated April 23, 2007.

4. Authorized Representative Name _____ Signature_____

Title_____ Date ___/___/___

Revised 7/29/2008