McLaren
ST. LUKE'S

Student/Agency/Allied Health IT Access Form

STUDENT/AGENCY/ALLIED HEALTH INFORMATION (students/professionals to complete)

Full Name (first, last):_____

School/Organization Name: _____

Learner's Program of Study (ie: Nursing, Pharmacy, Radiology, etc.): _____

Student ID: _____ Last 4 SSN: _____

Email Address: _____

Primary/Cell Phone: _____

Are you a re-occurring Student/Agency/Allied Health Professional? Yes ☐ No ☐

ACCESS INFORMATION ACKNOWLEDGEMENT

I hereby:

- Acknowledge that use and disclosure of protected health information (PHI) contained in the information each of the Hospital's HIPAA and other confidentiality and security policies. I agree to abide by the applicable policies.
- Acknowledge that I am responsible to ensure the confidentiality of PHI printed from McLaren St. Luke's applications and ensure its use will be proper and in a manner that does not compromise the confidentiality of the PHI.
- Understand that individual IDs and passwords must not be shared.
- Acknowledge that my McLaren St. Luke's application access rights will be revoked if I am no longer an employee of sponsoring physician or business associate.
- Agree that personal computers used to access McLaren St. Luke's information systems will be positioned or shielded such that the screens are not accessible or visible to the public or other unauthorized individuals in order to ensure the confidentiality of PHI.
- Acknowledge that I am responsible for reviewing the documentation provided by OurMSL. I understand that I am responsible for understanding and abiding by the information written in this documentation.

Student Signature: _____ Date: _____

Password / Username Information (IT to Complete)

ID: _____ Password: _____ Date Created: _____

Comments

School Clinical Coordinator: Email completed form to: studentintake@stlukeshospital.com

Agency/Allied Health: Return to McLaren St. Luke's Human Resource Dept.