BRIGHAM AND WOMEN'S HOSPITAL

The Center for Nursing Excellence · 1620 Tremont Street Boston, Massachusetts 02120

Privileges Request by BWH Staff for the Role of Visiting Faculty

Please TYPE responses in gray shaded area, print, obtain signatures, scan and email to BWHNursingCredentialing@partners.org

DATE BWH staff member ☐ yes ☐ no

Name:
First Middle Last

Home Address:

Email Address: DOB:

Preferred Contact Number: Gender: M☐ F☐

Last 4 digits of Social Security number:

MA RN License Number: Expiration Date:

Professional affiliation (NOT BWH):

Clinical Practice Area you will be visiting:

Semester start date: end date:

Has Confidentiality Agreement (page #2) been signed? YES☐ NO☐

REQUIRED FOR BWH AND NON BWH EMPLOYEES: Endorsement of organizational representative of requesting institution. I verify the person seeking privileges is qualified, capable, and prepared to perform the services for which they are seeking privileges and that a "no record" results from CORI check and equivalent criminal background checks in the applicant's state of residence have been done.

SIGNATURE OF SUPERVISOR/TITLE DATE

PRINT NAME email address TELEPHONE

REQUIRED For BWH/Partners Employees ONLY.

Endorsement of BWH/Partners immediate supervisor. I verify the person seeking re-access is qualified, capable, and prepared to perform the services for which they are seeking to maintain.

SIGNATURE OF SUPERVISOR/TITLE DATE

PRINT NAME email address TELEPHONE

PARTNERS HEALTHCARE SYSTEM
PARTNERS COMMUNITY HEALTHCARE
CONFIDENTIALITY AGREEMENT

Partners HealthCare System, its affiliates and joint venturers, and Partners Community HealthCare have a legal and ethical responsibility to safeguard the privacy of all patients and to protect the confidentiality of their health information. Additionally, Partners HealthCare System, its affiliates and joint venturers, and Partners Community HealthCare must assure the confidentiality of its patient, fiscal, research, computer systems, management and other business information. In the course of my employment/assignment at a Partners organization/practice, I may come into the possession of confidential information. In addition, my personal access code [User ID and Password] used to access computer systems is also an integral aspect of this confidential information.

By signing this document I understand the following:

1. Access to confidential information without a patient care/business need-to-know in order to perform my job - whether or not that information is inappropriately shared - is a violation of this policy. I agree not to disclose confidential or proprietary patient care and/or business information to outsiders (including family or friends) or to other employees who do not have a need-to-know.

2. I agree not to discuss confidential patient, fiscal, research, computer systems, management and other business information, where others can overhear the conversation, e.g., in hallways, on elevators, in the cafeterias, on the shuttle buses, on public transportation, at restaurants, at social events. It is not acceptable to discuss clinical information in public areas even if a patient’s name is not used. This can raise doubts with patients and visitors about our respect for their privacy.

3. I agree not to make inquiries for other personnel who do not have proper authority.

4. I know that I am responsible for information that is accessed with my password. I am responsible for every action that is made while using that password. Thus**,** I agree not to willingly inform another person of my computer password or knowingly use another person’s computer password instead of my own.

5. I agree not to make any unauthorized transmissions, inquiries, modifications, or purgings of data in the system. Such unauthorized transmissions include, but are not limited to, removing and/or transferring data from Partner’s computer systems to unauthorized locations, e.g., home.

6. I agree to log off a Partners workstation prior to leaving it unattended. I know that if I do not log off a computer and someone else accesses confidential information while the computer is logged on with my password, I am responsible for the information that is accessed.

Partners HealthCare System, its affiliates and joint venturers, and Partners Community HealthCare have the ability to track and monitor access to on-line records and reserves the right to do so. Partners HealthCare System, its affiliates and joint venturers, and Partners Community HealthCare can verify that those who accessed records did so appropriately.

I have read the above special agreement and agree to make only authorized entries for inquiry and changes into the system and to keep all information described above confidential. I understand that violation of this agreement may result in corrective action, up to and including termination of employment and/or suspension and loss of privileges. I understand that in order for any User ID and/or Password to be issued to me, this form must be completed.

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Signature of Employee / Physician / Student / Volunteer / Non-Partners Personnel Date

PRINT NAME