PHC PCIS Training Registration form for **External** Users

PCIS DATA SHARING LEADS TO PATIENT CARING

Providence HEALTH CARE
How you want to be treated.

(For Research Staff, Medical Office Assistants or other people working in a private practice medical office, such as Secretaries, Administrative Assistants and Receptionists that are external to VCH/PHC.)

If you have any questions, please e-mail PHC PCIS Training at
phcpcistrainingrequest@providencehealth.bc.ca

* Access will not be given if this form is incomplete *

PLEASE PRINT

Last name, First name, Middle Initial	Contact Phone Number:		ID Number:
Job Title:	**Dept/ Unit:**	**Site:**	**Email Address:**

A. PCIS Training Registration – PLEASE PRINT

Job Class:	Status:	PCIS Status:
☐ Medical Office Assistant (MOA) ☐ Clerical ☐ Research ☐ Other (please specify):	☐ Regular position ☐ Casual ☐ Temporary Position Start Date: End Date:	☐ New user ☐ Existing user Registered in CCRS: YES ☐ NO☐ CCRS course number: CCRS course date:
Research Staff: Please check all that apply: ☐ Employed by PHC ☐ Study funded by PHC		

B. PCIS User Access – PLEASE PRINT

AUTHORIZING PHYSICIAN TO COMPLETE THIS SECTION:
For staff from Medical Offices, the Physician must indicate which of the following are performed in their area: For research staff, the principle investigator must indicate which of the following are required: ☐ View Access **ONLY** (Demographics, Orders, Results, etc.)   ☐ Order Entry

Reason(s) for Access	☐ Clinical ☐ Research ☐ Other (please specify):

I have determined that the User has a '**need to know**' for performing their specific job duties and responsibilities regarding access to the information provided by the access privileges described above as an employee or representative of _____ (name of external legal entity) and I authorize the User to receive such privileges.

I agree to the **Terms of Use** attached to this form and understand that non-compliance may result in immediate termination of my User's access privileges and further legal action if warranted.

Physician Name:	Title:	Department:
Phone Number:	Email:	
Physician Signature:	Date:	

Research personnel must submit a copy of their Final Certificate of Approval with this registration request.

For access to our intranet site, please follow this link:
http://phcconnect/programs_services/pcis/pcis_training/page_74447.htm (only available from within PHC)

The signed form must be faxed to 604-875-4064 prior to training

Ver. 2012.01.21

Terms of Use

Your use of the PCIS system to which you have been granted access in connection with this Access Request Form (the "System") is subject to the following terms:

1. You will use the System and information contained therein only for the purpose(s) identified on the Access Request Form (the "Authorized Purpose(s)").

2. You will access information, including "personal information", as defined in the *BC Freedom of Information and Protection of Privacy Act* (FIPPA) ("Personal Information"), within the System only as necessary to perform your duties as an employee, service provider, contractor or representative of Vancouver Coastal Health Authority (VCH) or Providence Health Care Society (PHC) in connection with the Authorized Purpose(s).

3. For users whose Authorized Purpose(s) does not include "Clinical" or "Clinical Support", you will only access and use the minimal number of personal identifiers, such as names, PHNs, MRNs, birthdates, addresses, postal codes, phone numbers and other Personal Information that may be used to associate information to the individual to whom it pertains, necessary to perform your duties in connection with the Authorized Purpose(s).

4. You will not access your record or those of family, friends or others, unless you are directly involved in the ongoing delivery of care or other services to them through your relationship with VCH/PHC.

5. For users whose Authorized Purpose(s) is "Clinical" or "Clinical Support", you will only use and disclose Personal Information obtained through the System for purposes directly related to the ongoing delivery of care or other services to the individual the information is about.

6. You will not use or disclose Personal Information obtained through the System for research purposes, unless officially authorized by VCH/PHC and done in accordance with applicable VCH/PHC policies.

7. You will not disclose your password to others or allow others to use your account.

8. You will immediately report to VCH/PHC any loss or potential or actual unauthorized disclosure of Personal Information.

9. You will comply with all applicable VCH/PHC computer information system usage, privacy and other policies and applicable laws, including FIPPA.

10. You acknowledge that your use of the System will be monitored and recorded in an audit log, which is reviewed regularly to ensure compliance with this Terms of Use.

11. You will comply with this Terms of Use in respect of information obtained through the System whether in electronic or printed form.

12. You acknowledge that failure to comply with this Terms of Use may lead to disciplinary action, including revocation of access privileges, professional sanctions, suspension or termination of employment or services.

You also confirm having read and understood the following:

For VCH users or systems:
- [ ] VCH Information Privacy & Confidentiality Policy (only available from within VCH)
- [ ] VCH Information Privacy Frequently Asked Questions (only available from within VCH)

For PHC users or systems:
- [ ] PHC Information Privacy & Confidentiality Policy (only available from within PHC)

User Acknowledgement and Undertaking

By signing this Access request Form, you are confirming that all the information you have provided is true to the best of your knowledge and you agree to the Terms of Use set out above. Providing false information or non-compliance with these Terms of Use may result in immediate termination of your access privileges and further disciplinary action.

Print Name Clearly:	ID Number:
Signature:	Date: