Clinical Student/Instructor IS Access Request, Non-Disclosure & Acceptable Use Agreement

PROVIDENCE Health & Services Southwest Washington

Please complete all of the following information.

Student Personal Information		School Information	
Legal Last Name:		**School/Facility Name:**	
Legal First Name:		**School/Contact Name:**	
Middle Initial:		**Phone/Ext:**	
Date of Birth:		**Email:**	

Access Specifics			
Are you a current Providence Employee? (circle one)			Yes / No
Have you had access to Providence computer network in the past? (circle one)			Yes / No
If you have had previous access, what was your login ID?			
Access Start Date:		**Access End Date:**	
Please select the Providence Location where you will be a student/instructor:	☐ Providence Centralia Hospital ☐ Providence St. Peter Hospital ☐ Providence Medical Group Specify Clinic: _____		

Personal Identifier Data This will be used to validate your identity if you call the Providence Service Desk for assistance. Please answer all three of the questions with one word answers.	
What was your High school mascot?	
What was the name of your first pet?	
What is the first name of your best childhood friend?	

Student Acknowledgement & Signature		
By signing this access request, I acknowledge that all information contained within Providence Health Systems is considered confidential and should only be shared with others for business related purposes relative to my role. I accept responsibility for taking appropriate measures to secure my login and to keep my password private. I acknowledge that I have signed the following forms and they are on file with my school: ☐ Non-Disclosure & Acceptable Use Agreement ☐ Non-Employee Confidentiality and Nondisclosure Statement		
Student	***Signature:***	***Date:***