UTAH DEPARTMENT OF HEALTH
Bureau of Emergency Medical Services and Preparedness

Security Access Form to Prehospital Reporting System

Form must be TYPED

Full Name of Person Requesting Access: Job Title:	Select one: ◉ Request Access ○ Delete User Access
Phone number: Email address: Facility/Organization Address: Facility/Organization Name(s):	Check all that apply: ☐ Cardiac ☐ Donor Services ☐ Health Information Management ☐ Public Safety ☐ Regional Data Sharing ☐ STEMI ☐ Stroke ☐ Trauma ☐ Other:
Supervisor Name:	Supervisor email:
Justification for access or modification:	

CONFIDENTIALITY STATEMENT for Department of Health Users ONLY:
By signing this form, I certify that I have read and agree to abide by the provisions of the State of Utah Information Technology Resources Acceptable Use Policy (https://rules.utah.gov/publicat/code/r895/r895-007.htm).

CONFIDENTIALITY STATEMENT for non-Department of Health Users:
As an authorized user of the Prehospital Reporting System, I acknowledge, agree and shall adhere to the following:

1. *I will access or attempt to access only patient information that is directly related to the treatment and/or operational needs of patients to whom I have a clinical and/or operational relationship or to meet reporting requirements.*
2. *I understand that as a Prehospital Reporting System user it is my responsibility to limit my access to only that data needed to perform my assigned job duties. I understand that I am not permitted to access any patient information except as authorized to perform my assigned duties.*
3. *I will not disclose or discuss any confidential information with others who do not have a need to know it.*
4. *I will maintain the confidentiality of my Prehospital Reporting System login and password, and will not share it with any other individuals.*
5. *I will notify the Department of Health if my password has been seen, disclosed, or otherwise compromised, and will report activity that violates this agreement, privacy and security policies, or any other incident that could have any adverse impact on the confidential information.*
6. *I understand that the Department of Health may log, access, review, audit, or otherwise utilize information stored on or passing through its systems in order to manage systems and enforce security.*
7. *I understand the Department of Health may terminate my access at any time.*
8. *I agree to notify the Department of Health upon termination of my employment or any change in my assigned job duties where I am no longer required to access the Prehospital Reporting System. I will not access the system upon my termination or change in assigned job duties.*
9. *This pledge expires upon termination of employment or role at Facility/Organization.*

User signature:	Date of Request: