STATE OF ALASKA
DEPARTMENT OF CORRECTIONS

NETWORK ACCESS - PERSONNEL SECURITY REQUEST & UPDATE FORM

Check Appropriate Box: ☐ **NEW** ☐ **CHANGE** ☐ **TRANSFER** ☐ **DELETE**
REQUIRED

APPLICANT TO COMPLETE THE BELOW INFORMATION REQUIRED *EFFECTIVE DATE:*

LAST NAME: FIRST NAME: MI:

TITLE: PHONE: DATE:

EMAIL ADDRESS: DOC FACILITY:

DATE OF BIRTH: DRIVER LICENCE (ST\NUMBER):

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_____ INITIAL
- I will not access department electronic resources or systems (i.e., File Server, EHR, ACOMS) except by using the unique user id and password assigned to me. I understand that my password is confidential and will not disclose it to anyone.

_____ INITIAL
- I understand information obtained through physical or electronic files, EHR, ACOMS or other department systems is confidential and that I may not access it for personal curiosity or gain, to benefit or injure another person, except as specifically authorized to perform job duties. I understand I must be able to articulate the business reason (the "why") for searching; or obtaining; any criminal justice information (CJI) or electronic protected health information (ePHI).

_____ INITIAL
- I understand that I may not release information obtained through physical or electronic files, ACOMS, EHR, or other department system except as specifically authorized by DOC or under AS 12.62.160, 13 AAC 68.300-345.

_____ INITIAL
- I will not disclose information about ACOMS, EHR, or other department systems security measures, access, operating procedures, equipment or programs without specific authorization from the Department of Corrections.

_____ INITIAL
- During my duties, I may have direct or indirect access to Inmate Medical Information, in writing or verbal communication. I understand the use and disclosure of patient information is governed by the rules and regulations established under the Health Insurance Portability and Accountability Act (HIPAA) of 1996. I acknowledge that while performing my assigned duties I may have access to, use, or disclose confidential health information. I hereby always agree to handle such information in a confidential manner.

_____ INITIAL
- I understand direct access to DOC's Electronic Health Records (EHR) system, DocSynergy, shall only be granted to division of Health and Rehabilitation Services (HRS) employees and contractors for the purposes relating to patient treatment, payment or clinic operations.

_____ INITIAL
- I have read and understand State of Alaska Information Security Policy ISP-172 Business use and Control (Business Use/Acceptable Use)

I understand that the Department of Corrections will maintain a record of my electronic actions, (i.e., File Server, EHR, ACOMS), and the record(s) may be used to audit my use at any time, and record(s) may be released to HR, my supervisor or division director for an administrative investigation and to a law enforcement agency for a criminal investigation. In addition to any criminal, civil, or employee disciplinary actions that may result from such investigations, if I am found to have violated this agreement the Department of Corrections may take the following action:

PERMANENTLY REVOKE ACCESS

STATE OF ALASKA
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REQUESTING ACCESS TO THE FOLLOWING:

☐ File Server	List of Folders on the Group Drive (G)				
☐ Email	***Note:*** For New Employees, Email is setup when user information has been added to HR System, please ensure to coordinate with DOC HR to setup New Employees as **Pre-Hire** so accounts can be created first day of work.				
☐ ACOMS	**Complete form 650.01C, forward to local ACOMS TAC or DOC.CJIS@alaska.gov**				
☐ State Mainframe	**ADDITIONAL PAPERWORK REQUIRED:** https://oit.alaska.gov/mainframe/				
☐ EHR	Access to Electronic Health Records, forward this form to: DOC.EHR.Helpdesk@alaska.gov	☐ NURSE	☐ HP	☐ OTHER	

(R) – Read Only (RUI) – Read, Update, Insert

Additional Request or Instruction for IT (.i.e. Same access as User: <fillinblank>):

I understand and agree that my failure to fulfill any of the obligations set forth in this Agreement and/or my violation of any terms of this Agreement shall result in my being subject to appropriate disciplinary action.

Applicant Name:

Applicant Signature: _____ Date: _____

If applicant is to have **UNESCORTED** access to a DOC Office, Facility, or ACOMS, they must complete security awareness training within six weeks of hire. Please coordinate with your office APSIN\ACOMS TAC to obtain Security Clearance and sign applicant up for training provided by DPS.

I certify that I have reviewed the above information with the applicant and coordinated an FBI Based Nationwide Fingerprint Background check as required by 13 AAC 68.215.

Supervisor\Hiring Manager:

Supervisor Signature: _____ Date: _____

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SEND COMPLETED FORM TO:

Network Access form: doc.networkhelp@alaska.gov
If requesting EHR cc EHR: DOC.EHR.Helpdesk@alaska.gov
ACOMS Access form: doc.cjis@alaska.gov