



STATE OF ALASKA  
DEPARTMENT OF CORRECTIONS

**NETWORK ACCESS - NON-DOC 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:

COMPANY:  EMAIL ADDRESS:

DATE OF BIRTH  DRIVERS LICENSE (ST\NUMBER):

DOC FACILITY:  IF CONTRACTOR CONTRACT LENGTH

\*\*\*\*\*

- 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  
DEPARTMENT OF CORRECTIONS

REQUESTING ACCESS TO THE FOLLOWING:

<input type="checkbox"/> File Server	List of Folders on the Group Drive (G)			
<input type="checkbox"/> Computer Only (AKDOC\GCCC)	This allows user to log into computer but no access to the File Server. <i>Access to Internet</i>			
<input type="checkbox"/> Computer w\ MS Office Suite	<b>Requires Business Reason: DOC IT Manages Sponsored Email Account Microsoft O365 G5 includes Email access. EMAIL is OPTIONAL, but SOA Account required for Office Suite. There is a Cost Association of approximately \$650.00/year.</b>			
<input type="checkbox"/> SOA – DOC Sponsored Email	Requires Business Reason: <b>DOC IT Manages Sponsored Email Account</b> Login-enabled mailbox (Email Only). <b>There is a Cost Association of approximately \$300.00/ year.</b>			
<input type="checkbox"/> ACOMS	<b>Please completed FORM 650.01C</b>			
<input type="checkbox"/> EHR	Access to Electronic Health Records, forward this form to: <a href="mailto:DOC.EHR.Helpdesk@alaska.gov">DOC.EHR.Helpdesk@alaska.gov</a> (HARS Contractors)	<input type="checkbox"/> NURSE	<input type="checkbox"/> HP	<input type="checkbox"/> OTHER

Business Reason: **Be specific to what information you require access to. (REQUIRED)**

**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 Facility, ACOMS, and or obtain a SOA Sponsored Email, they must comply with FBI CJIS Security Policies. Security Clearance will be denied for anyone who has been convicted of a **felony** or **misdemeanor** in this state or another jurisdiction or who is a **fugitive** from justice. If Denied due to misdemeanor, an appeal can be made ([13 AAC 68.215](#)).

**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.**

SPONSOR:

**Sponsor Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

If Contractor Attach to this form:  [DPS Personal Security Clearance Form](#)  [FBI Security Addendum](#)

\*\*\*\*\*

**SEND COMPLETED FORM TO:**  
[doc.networkhelp@alaska.gov](mailto:doc.networkhelp@alaska.gov) and if requesting EHR cc [DOC.EHR.Helpdesk@alaska.gov](mailto:DOC.EHR.Helpdesk@alaska.gov)