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Medicine

AP User Account Form

User Information

☐ New ☐ Modify

First Name: (required) _____ Middle Initial: _____ Last Name: (required) _____

Phone: (required) _____

Email Address: (required) _____

Group: (required) SOM Departments

Access

Department 1: (required) _____ Department 2: _____

Division Access - If not ALL, please list all that apply from attached division list:

Division: ALL	Division:	Division:
Division:	Division:	Division:
Division:	Division:	Division:
Division:	Division:	Division:
Division:	Division:	Division:

Dollar Authority

Approval $: $0 - Staff

The individual requesting access to University of Colorado Medicine (CU Medicine) COR360 computer system understands that these resources are intended for CU Medicine business purposes. The individual also accepts sole responsibility for the assigned account and the actions attributed to that account and understands that sharing the account and its password is strictly prohibited. When accessing this computer system, the confidentiality, integrity, and availability of the data and accounts must be safeguarded at all times. Passwords should be complex and must be protected from disclosure. False, misleading, inaccurate, or damaging data may not knowingly be entered into this computer system. Confidential CU Medicine information contained or entered into this computer system must not be accessed or disclosed unless such access or disclosure is part of the individual's assigned job duties, and then only the minimum necessary. Information will remain confidential indefinitely *including after the user's access to the system ends*. The individual must adhere to their organization's respective agreements with CU Medicine. Any account not used within a 60-day time period will be disabled. The individual is subject to having all activities on this system monitored and recorded. Anyone using these systems expressly consent to such monitoring. Any violation of these security policies may result in account termination and/or legal remedies.

I HAVE READ AND UNDERSTAND THE ABOVE PARAGRAPH AND WILL COMPLY WITH THE RESPONSIBILITIES AND CONFIDENTIALITY OF THE INFORMATION AND RESOURCES MADE AVAILABLE TO ME.

_____ _____

User's Signature (printed) Date

Send form to DFA for approval

Authorization

Submitted By: _____ Date: _____

Title: _____ Phone: _____

Send completed form to CU Medicine AP Dept