ELECTRONIC ACCESS AGREEMENT

Name (Please Print): _________________________________________________________________

Employer/Sponsor: Medical Center  HSF  UVA Academic Division

Department: ____________________________ Date: ____________________________

1. I will not disclose my password to other individuals, and acknowledge that the combination of my computing ID and password is considered equal to my electronic signature. I understand that I will be held responsible for the consequences of any misuse occurring under my computing ID and password due to any neglect on my part.

2. I will not use another person’s computing ID and password. If I have reason to believe that my computing ID and password, or those of another individual have been compromised or are being used by a person other than the individual to whom they were issued, I will report it to my agency Security Office.

3. I agree to access and alter only the information for which I have responsibility or authorization, and not to view information that I have no need to see as part of my responsibilities. Access to or use of a University, Medical Center or Health Services Foundation information system and the data it contains for my own personal gain or profit, for the personal gain or profit of others, or to satisfy personal curiosity is strictly forbidden.

4. I will respect the confidentiality of individuals to whose information I have been given access. I will not view or disclose that information except as required by my responsibilities and as allowed by University, Medical Center and Health Services Foundation policies and applicable law.

5. I understand that the transactions processed with my electronic access may be audited, and appropriate action will be taken if improper uses are detected.

6. I agree to follow the privacy, security, and other computing policies and procedures established by the University, Medical Center, and Health Services Foundation, as well as state and federal security and privacy laws and regulations, that apply to the use of my computing ID and password and to the information and the systems I access.

7. I understand these concepts apply to both fixed and mobile devices (such as, but not limited to PDAs, Blackberrys, and text-enabled pagers). I also agree to safeguard the information I access and the devices assigned to me and report any losses promptly to the appropriate authorities.

8. My signature below indicates that I have read, understand, and agree to abide by these requirements. Failure to do so may result in the revocation of my system privileges and/or disciplinary actions, including termination of my employment.

__________________________
Signature

Send to appropriate human resources department identified below:

University of Virginia Human Resources
P.O. Box 400127
Charlottesville, Virginia 22904
Fax: 434-924-6869

University of Virginia Health System Human Resources
P.O. Box 800567
Charlottesville, Virginia 22908
434-982-4122

University of Virginia Health Services Foundation Human Resources
500 Ray C. Hunt Drive/Messenger Mail
Box 800504
Charlottesville, Virginia 22903
434-295-1000

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