OHSU Access for Veterans Administration

Business-to-Business Affiliate

This document applies to all users of OHSU computing resources. The undersigned hereby agrees that accounts and access granted in their name on the OHSU network and computers will be used only in accordance with the following guidelines. User agrees to abide by the Acceptable Use of Computing and Telecommunication Resources Policy (11-20-010) and will:

1. Protect and keep private accounts that are granted for the sole use of the undersigned. Permission to use these accounts may not be designated to any other.
2. Use only computing resources for which specific authorization has been granted.
3. Protect the confidentiality of patient data and proprietary information and the privacy of other users.
4. Comply with pertinent federal,Oregon, and other applicable laws; all university rules and policies; and all contracts and licenses.
5. Refrain from use of OHSU computing resources for personal commercial or financial gain.
6. Limit use of computing resources so as not to interfere with the activity of other users.
7. Follow OHSU policies to ensure the security and integrity of the network.
8. Not represent him/herself as speaking or acting for OHSU unless properly and explicitly authorized.

Access may be monitored under conditions specified in the Acceptable Use of Computer Resources Policy.
Use of the network for personal purposes is limited.
Violation of any of these policies may result in the disabling of all OHSU computer system accounts or other disciplinary action for the undersigned.

Affiliate Information

First Name _____ Middle Initial _____

Last Name _____ Birth Month/Day _____

ID Type _____ Enter ID Here _____

Phone _____ Email _____

Are you credentialed at OHSU? _____ Title _____

Select your role. _____

Authorizer Information

VA Research authorizer:
Michael Davey 095-55587
daveym@ohsu.edu

VA Medical Service authorizer:
Sharon Anderson 095-55591
anderssh@ohsu.edu

Affiliate Signature: _____

By signing this form you are agreeing to abide by the Acceptable Use of Computing and Telecommunication Resources Policy (11-20-010) and Patient Confidentiality Policy (01-05-012)

Authorizer Signature: _____

By signing this form you are attesting that the information on this form is accurate to the best of your knowledge.

*Requests will not be processed unless all information is typed in correctly and the appropriate authorizer has signed off on this form. Allow **2 business days** for account to be processed. Upon completion fax to 503-494-2324.*

Print Form