WAMC IMD IN-PROCESSING FORM

The Proponent Agency is MCXC-IMD

Requirements for this information are mandated by Army Regulation 25-2 dated 14 November 2003 and the Health Insurance Portability and Accountability Act 1996 for computer access will be granted. The Womack Army Medical Center's (WAMC) Identification (ID) Badge is required before a computer account will be issued In Accordance With (IAW) MEDCEN Memo 190-2 paragraph 5a.

1. ☐ **IN-PROCESS REQUEST** ☐ **BADGE REQUEST ONLY** ☐ **REASSIGNMENT** ☐ **ACCOUNT MODIFICATIONS** (CHCS, AHLTA)

a. Rank: _____ _____ _____ _____

(Mr. or Ms. if civilian) First Name Middle Name Last Name

SSN: _____ Birth Date: _____ Place of Birth: _____

City State

b. Your status: (check one)

☐ Military ☐ GS/WG ☐ Student ☐ Red Cross ☐ Pink ☐ Temporary ☐ Contract: _____

(Name of Company/Contractor)

c. Dept: _____ Section: _____ Office Symbol: _____ Bldg. #: _____

Position Title: _____ Work Phone #: _____ Room #: _____

d. My Mail.Mil address is: _____ **YOU MUST FILL THIS OUT**

Do you have a current Common Access Card (CAC)? ☐ YES ☐ NO ☐ CAC EXEMPT

Do you know your 6-8 digit CAC Personal Identification Number (PIN)? ☐ YES ☐ NO

Your 10 digit CAC certification number is: | | | | | | | | | | |

2. Authorized Representative *NOTE: Only the person listed on the Delegation of Authority Signature Card is authorized to sign.*

Authorizing Personnel (Please Print): _____ _____ _____

Rank First Name MI Last Name

Department: _____ Work Phone: _____

Delegating of Authority Signature: _____ Date: _____

3. PTM&S Personnel Security/Background Investigation Verification

NOTE: Sections 1 a-d, 2 and 4 a-d, MUST be completed before this section.

I verify that a favorable National Agency Check/Local Records Check has been: ☐ Started ☐ Completed on the requesting user:

Date: _____, Type: _____. I will notify the Information Assurance Security Officer,

who will in turn notify the appropriate Information Management Division (IMD) personnel to terminate this acess to the WAMC Network if the investigation status of the user changes.

Security Manager's Name: _____ Phone #: _____

Signature: _____ Date: _____

NOTE: If background check is started, but not completed, access will be reviewed six (6) months after the investigation initiation. This access will be granted only upon a written request by the user's supervisor, commander's concurrence and the DAA signature. If the person is not a U.S citizen, the investigation must be completed and favorably adjudicated prior to access being granted.

DATA REQUIRED BY THE PRIVACY ACT OF 1974

Authority 5CFR, Vol Chap III

Principal Purpose To grant computer access to the WAMC IS

Routine Uses Used to determine eligibility and access needed for position assigned.

Disclosure Providing the required data will facilitate granting computer access. Failure to provide the requested information could result in denied access to the computer network.

4. NETWORK ACCESS INFORMATION

NOTE: To be completed by the person on the signature card. Authorizing personnel must INITIAL each account.

a. ☐ Outlook ☐ ESSENTRIS ☐ LOG IN ACCESS ONLY

b. Job Type:

☐ Physcian (MD) ☐ Physcian Assistant ☐ Nurse Practitioner

☐ ** Resident ☐ ** Nurse (RN) ☐ **LPN

☐ **Technician/Corpsman ☐ **Clerk/MSA ☐ OTHER, PHR, FT*

**** For AHLTA access this requires the form WAMC 2711 to be filled out****

c. CHCS (select access level below) NOTE: Authorizing personnel must INITIAL each account.*

NOTE: Supervisor must submit a Provider Profile (WAMC Form 2711) to Clinical Operations Division for employees that are required to have nurse signature class order entry access.*

*** Strictly for ancillary service employees.**

☐ Physcian Menu* ☐ Nursing Menu ☐ Pas Menu* ☐ Results Retrieval

☐ Laboratory Menu* ☐ Pharmacy Menu* ☐ Radiology Menu* ☐ PAD Menu

☐ **CHCS NO LONGER REQUIRED

Has the employee been trained on CHCS? YES NO If NO, submit training request via WAMC. If YES, specify the location of training below.

Location: _____ Date of Training: _____

d. AHLTA (if applicable, select access level below). AUTHORIZING PERSONNEL PLEASE INITIAL THE AHLTA ASSIGNED ROLE(S).

NOTE: Supervisor must submit a Provider Profile (WAMC Form 2711) to Clinical Operations Division for ALL AHLTA ACCESS.

☐ Provider (co-sign) ☐ Provider (can sign) ☐ **Non Provider (w_NPOE) ☐ Clerk

☐ Immunization Entry ☐ Access to Sensitive Documents/results

Did the employee have an AHLTA account at a previous duty station? YES NO If NO, submit training request via WAMC Intranet.

If YES specify: Location: _____ Date of Training: _____

***NOTE: Prior to account creation, all employees must have a CHCS provider file (PRO) created by Clinical Operations Division and a CHCS provider profile (PPRO) created by their department/clinic scheduling supervisor. If the employee works in multiple clinics, each associated clinic must create a provider profile (PPRO) for the employee.**

5. TRAINING REQUIREMENTS FOR NETWORK ACCESS ***OFFICIAL USE ONLY: To be completed by HIPAA,IA and Personnel Security ONLY***

☐ Received Cyber Awareness Challenge Training Date: ☐ ☐ Information Security Program Training

☐ Received HIPAA Training

***IMPORTANT* If you DO NOT receive credit in ATCTS or DTMS within 72 hours, you must take your final exam certificate "STEP II" to IMD/IA office. POC: Mrs. Bradley 907-7765 or Ms. Huddleston 907-8911.**

6. ASB WAMC Badge Information ***Note: This is your final step. Make sure everything is properly completed before submission.***

Check One: New Badge Badge Replacement User Account (IMD Representative: verify the statement below then initial to confirm).

☐ **The person listed in Section 1 has signed the WAMC Acceptable Use Statement and Information System (IS) Account Request Form.**

Badge Number: _____ Issue Date: _____

Badge Receipt Signature: _____

Signature of the Issuer: _____