SECURITY REQUEST FOR ACCESS TO DEVELOPMENTAL DISABILITIES SYSTEM

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEVELOPMENTAL DISABILITIES
SFN 94 (2-2023)

Clear Fields

Type of Request	Effective Date	System
☐ Add Security ☐ Remove Security		☐ Therap ☐ QMS ☐ AEPSi

Employee Name		
Telephone Number	Email Address	
Region	Infant Development Provider	
Job Title	DDPA/DDPM FTE	Super Role
Credentials (attach documentation)		

***Confidentiality Agreement** (by initialing each of the following statements, you agree to comply with the HHS policy on confidentiality covered in Administrative Services Manual Chapter 110-01 and Human Resources Manual Chapter 317-01)**:**

_____ I will use this User ID to access information that is appropriate and relevant to complete my critical job elements.

_____ I understand an access history log is maintained. Information accessed beyond my "need to know" and/or disclosed is a violation of HIPAA Privacy rules, and state and federal confidentiality laws. Such violations in access can result in disciplinary actions, including termination, and/or legal penalties.

By typing my name below, I am signing this application form electronically. I agree that my electronic signature is the legal equivalent of my handwritten signature. I attest, subject to the penalties of perjury that I am the individual completing this application and that I have provided accurate information.

Employee Signature	Date
Supervisor Signature	Date