eHealth CyberSanté NB
Electronic Health Record
Dossier de santé électronique

EHR ACCESS REQUEST FOR PUBLIC SECTOR USER

Department of Health
Tab to go from one field to another or click on the grey box beside each item.
Please submit the completed form to EHRAccess@gnb.ca or fax the completed form to: (1-506) 462-2010

1. USER INFORMATION – to be completed by the requester

a. Full Name	
b. Job Title	
c. Department / Specialty	
d. Work Location or facility name and zone number For those also working in the private sector, please enter all your work locations.	
e. Employee Number (not required for physicians) 6 digits for Vitalité, 8 digits for Horizon.	
f. Business Telephone Number	
g. Business Address	
h. Preferred E-mail Address	
i. Username or User-ID (Active Directory username) ID used to log on to network at the beginning of your work day.	

j. Role (select one only)

PHYSICIANS AND NURSES:
- ☐ Physician - General Practitioner
- ☐ Physician – Specialist
  - ☐ eConsult Specialist
- ☐ Nurse Practitioner
- ☐ Midwife
- ☐ Physician Assistant
- ☐ Registered Nurse
- ☐ Licensed Practical Nurse

ALLIED HEALTH PROFESSIONS:
- ☐ Audiologist
- ☐ Dietitian
- ☐ Occupational Therapist
- ☐ Physiotherapist
- ☐ Psychologist
- ☐ Respiratory Therapist
- ☐ Social Worker
- ☐ Speech Language Pathologist

MEDICAL LEARNERS: (indicate until date)
- ☐ Physician - Student / Resident
  - Until (add date):
- ☐ Nurse Practitioner - Student
  - Until (add date):
- ☐ Pharmacist – Student / Resident
  - Until (add date):

PHARMACY:
- ☐ Pharmacist
- ☐ Pharmacy Technician

OTHER PROFESSIONS: (in alphabetical order)
- ☐ Coder - Trauma
- ☐ DI Technologist
  - ☐ Involved in EHR DQ activities
- ☐ Laboratory Technologist
  - ☐ Cytotechnologist
  - ☐ Involved in DQ activities
- ☐ Radiation Therapist /Oncology Coordinator
- ☐ Trauma Registry Manager
- ☐ HIM staff involved in EHR DQ activities

DOH AND SNB STAFF:
- ☐ Cancer Registry staff
- ☐ Cancer Screening staff
- ☐ EHR Business Team
- ☐ EHR Application Support Team
- ☐ OPOR Registry Unit
- ☐ SNB Information Technology staff
  - ☐ Integration team ☐ Application team

OTHER:
- ☐ Access to Provider Index Only
- ☐ Other / Specify :

NOTE: For prescribers who prescribe monitored drugs and licensed pharmacists who dispense monitored drugs

defined as "participants" by the Prescription Monitoring Act, this EHR access request represents an application to be registered in the Prescription Monitoring Program (PMP).

2. USER ACKNOWLEDGMENT - To be completed, signed and dated by the requester.

I		agree that:
	ENTER YOUR NAME (PRINT)	

1. I understand that the personal health information (PHI) stored in the EHR is confidential and must only be used for providing or assisting in the provision of health care.
2. I understand I may not view or conduct searches for information about patients outside of my circle of care; including my own EHR record or the records of family members.
3. I must take reasonable steps to protect my EHR access information from unauthorized use.
4. I will not share my username, password or other EHR access information with anyone and I will use a complex password.
5. I am responsible for any unauthorized disclosure of personal information regarding clients/patients through the inappropriate use of my authorized access.
6. I will ensure that patient information is not made available to unauthorized individuals by way of printing,display, etc.
7. I understand that I will get a read-only access and printing is restricted to authorized users only.
8. I will not download personal health information to the hard drive on my work or personal computer(s) or any portable storage devices.
9. I will immediately notify the EHR Administrative office by e-mail if my account has been, or may have been, compromised in any way. E-mail address: EHRAccess@gnb.ca
10. I will notify the EHR Administrative office by email within 5 working days when it has been determined that access to the EHR is no longer required. EHRAccess@gnb.ca
11. The Department of Health may revoke my access if I fail to comply with my obligations outlined in this form.
12. The Department of Health may revoke my access if I have not logged into the EHR for a period greater than 4 months.
13. I understand that usage of the EHR will be monitored.
14. I understand that I will not be granted access to the EHR before I complete the online EHR privacy training.

By signing below, I acknowledge that I have reviewed, understand, and agree to the above. I also understand that the Department of Health may revoke my access if I fail to comply with my obligations.

Signature of requester/user	
Date	
Language of choice for training?	☐ ENGLISH ☐ FRENCH

3. SUPERVISOR AUTHORIZATION – To be completed by the requester's supervisor. This section is not required for Physicians.

I authorize the above named individual to have access to the EHR and declare that the individual has been authenticated to be the individual identified in section 1 of this form.

I verified the following:

a. All the needed information is complete and accurate;
b. The role selected is the individual's role within our organization;

and I will notify the EHR Administrative office by e-mail within 5 working days when it has been determined that this user no longer requires access to the EHR. EHRAccess@gnb.ca

Supervisor full name (PRINT)	
Supervisor title	
Supervisor signature	
Date	
E-mail address	
Telephone number	

Please submit the completed form to EHRAccess@gnb.ca or fax the completed form to: (1-506) 462-2010
If you have any questions about access, send an email to: EHRAccess@gnb.ca