

RESEARCH COLLEGE OF NURSING

**2525 East Meyer Boulevard
Kansas City, Missouri 64132**

Unclassified Student Application

I am applying for:

Family Nurse Practitioner Track Executive Nurse Practice Track Nurse Educator Track
 Executive Nurse Certificate* Nurse Educator Certificate*

*Certificate Program requires a BSN and a Masters in Nursing or Health Related Field.

I am not planning to complete a Masters or Certificate at Research College of Nursing College or University you are currently attending, if applicable _____

Are you currently or have you ever been employed by HCA? Yes No

If Yes, which affiliate _____

I plan to enroll in (list year) _____ Fall Spring Summer

Have you previously submitted an application to Research College of Nursing? Yes No

Mr Miss Mrs

Last Name _____ First Name _____ Middle _____

Maiden Name _____ E-Mail Address _____

Social Security Number _____ Telephone _____

Home Address _____ City, State, Zip _____

Are you a US Citizen? Yes No Are you a permanent resident of the US? Yes No

If no, Country of Citizenship _____ Visa Status _____

Have you ever been dismissed from any school for disciplinary reasons? Yes No

Have you ever been convicted or pleaded guilty to a felony? Yes No

If you answered yes to either questions, please attach an explanation.

List all previous Colleges and Universities attended and degrees awarded.

College/University	City/State	Years of Attendance	Date of Graduation	Degree Awarded

I certify that, to the best of my knowledge, all statements I have made in this application are complete and true. Incomplete or false information will result in the denial of this application or in my subsequent dismissal from Research College of Nursing.

Signature **Date**

Optional Statistical Information:

American Indian/Alaska Native Asian Black/African American Hispanic/Latino White
 Native Hawaiian/ Other Pacific Islander Non-Resident Alien Race & Ethnicity unknown Two or more races

Completed HCA IT&S Consolidated Access Form, available on the college website, must be submitted with this application.

<http://www.Researchcollege.edu> FAX Application and 3 page form to (816) 995-2813 ATTN: Jo Heglund

FAX TO: 816-995-2813

Complete * items on
1st and last page.
FAX all 3 pages.

HCA Midwest Division

IT&S Consolidated Access Request Form

Phone: 816-276-4357

Fax: 1-866-770-4947

This information will be kept confidential to the extent allowable by law.

() Employee Student/Agency/Temporary Employee () Vendor () Physician/Office Staff

YOU MUST USE YOUR LEGAL FIRST AND LAST NAME ON THIS FORM: PLEASE NOTE ANY ALTERNATE FIRST NAMES YOU PREFER. Your name below must match the name on any professional license you have.

User Information:

Last Name: *		First Name: *		MI: *
Home Phone: *		Date of Birth: *		Social Security Number: *
Facility/COID: 03123		Dept #: 869		Department Name: Research College of Nursing
Job Title: Student		Start Date:		Universal (3-4) ID:
Supervisor Name:		Supervisor 3-4:		Phone: Date:
Supervisor Signature:				

Student/Agency/Temporary Employee or Vendor, please complete this section:

Contracting Company / School Name:	
Phone:	Contract Expiration Date:

Select User Role:

Please circle the User's primary Job Role				
CEO	CFO	CNO	COO	VP
Accountant	Cook	Pharmacist	Specialist Human Resources	Technologist Lab
Admin Assistant Exec	Coordinator	Pharmacy Buyer	Social Worker	Technologist MRI
Analyst Coding	CV Technologist	Registrar Cancer	Technician Anesthesia	Technologist Nuclear Medicine
Associate Radiology	Dietitian	RN Case Manager	Technician EEG	Technologist Radiology
Associate Technical HIM	Director	RN Charge Nurse	Technician ER	Technologist Ultrasound
Assistant Anatomical	Ethics Compliance Officer	RN Clinical Manager	Technician GI Lab	Therapist Cert. Hand
Assistant Controller	House Supervisor	RN Continuum of Care	Technician Lab	Therapist Occupational
Assistant Director	Housekeeper	RN Patient Educator	Technician OB	Therapist Physical
Assistant Nutrition Care	Instructor	RN Staff Educator	Technician OR	Therapist Respiratory Cert.
Assistant Physical Therapist	Liaison Fac Compliance	RN Staff Nurse	Technician Patient Care	Therapist Respiratory Reg.
Asst. Pt. Svcs/Transp	Maintenance Engineer	RN System Auditor	Technician Pharmacy	Transcriptionist Med
Chaplain	Manager	Secretary Area/Dept	Technician Rehab	Unit Secretary
Clerk	Nurse Intern	Security Officer	Technician Respiratory Non-Cert	Volunteer
Clerk Accounting	Nurse Recruiter	Security Specialist	Technician Sterile Processing	Worker Food Service
Computer Operator	Operating Engineer	Speech Pathologist	Technical Assc. Rad	
Controller	Operator PBX	Specialist Clinical Documentation	Technologist CT	
For Lab/Chemistry List user's Primary area:				
For Cardiac/Cardiovascular List user's Primary area:				

Select Applications to which access is needed

<input checked="" type="checkbox"/> Network	Like User: RCON Student	
<input checked="" type="checkbox"/> Microsoft Outlook	X	Please obtain signature of HDIS, VP or above in the box to the left for Outlook and Remote Access.
<input type="checkbox"/> Remote Access	What will you need to access remotely?	
<input checked="" type="checkbox"/> Simplified Remote Access		
<input checked="" type="checkbox"/> CPCS (Meditech) / MOX	Role or Like User: RN	Facilities: All Midwest Facilities
<input type="checkbox"/> Genus MD	<input type="checkbox"/> Physician <input type="checkbox"/> Office Staff	Completion of the online Genus form is still required before access can be completed.
<input type="checkbox"/> SMS (ALCH)	Like user:	User's Name:
<input type="checkbox"/> Host (Oasis)	Please fill out Section II on page 3 **REQUIRED	
<input type="checkbox"/> Document Direct/View Direct	Please fill out Section I on page 3 **REQUIRED	
<input type="checkbox"/> PLUS Productivity System	Security Level:	Department Numbers:
<input type="checkbox"/> Smart**	Please fill out Section III on page 7 **All Signatures are required	<input type="checkbox"/> Material Mgmt <input type="checkbox"/> Accounts Payable
<input type="checkbox"/> Vista	COIDS:	
<input type="checkbox"/> XPO	Access Type: <input type="checkbox"/> View <input type="checkbox"/> View/Print <input type="checkbox"/> Scheduler	
<input type="checkbox"/> PACS	Access Type: <input type="checkbox"/> Physician <input type="checkbox"/> Radiologist <input type="checkbox"/> Nurse <input type="checkbox"/> Technician <input type="checkbox"/> Clerical <input type="checkbox"/> Super User	
<input type="checkbox"/> Facility Scheduler	Departments: Role:	
<input type="checkbox"/> Kronos iSeries	Note: The 'Kronos iSeries Phase II' online course in Healthstream must be completed prior to being granted access. Fax the completion certificate to Service Desk at 1-866-770-4947.	
Departments:		
<input type="checkbox"/> NeoData <input type="checkbox"/> QS	<input type="checkbox"/> GHX <input type="checkbox"/> OnBase <input type="checkbox"/> Staples Please fill out form on page 4	<input type="checkbox"/> MUSE <input type="checkbox"/> Camtronics <input type="checkbox"/> Telerad <input type="checkbox"/> LumedX Like User:
<input type="checkbox"/> ECIN Please fill out Form page 6	<input type="checkbox"/> Federal Express	<input type="checkbox"/> Krames Facilities:
Like User:		
<input type="checkbox"/> PowerScribe	<input type="checkbox"/> Teletracking/Bedtracking	
<input type="checkbox"/> Other	Please Specify:	

Confidentiality and Security Agreement

I understand that the facility or business entity (the "Company") in which or for whom I work, volunteer or provide services, or with whom the entity (e.g., physician practice) for which I work has a relationship (contractual or otherwise) involving the exchange of health information (the "Company"), has a legal and ethical responsibility to safeguard the privacy of all patients and to protect the confidentiality of their patients' health information. Additionally, the Company must assure the confidentiality of its human resources, payroll, fiscal, research, internal reporting, strategic planning, information, or any information that contains Social Security numbers, health insurance claim numbers, passwords, PINs, encryption keys, credit card or other financial account numbers (collectively, with patient identifiable health information, "Confidential Information"). In the course of my employment / assignment at the Company, I understand that I may come into the possession of this type of Confidential Information. I will access and use this information only when it is necessary to perform my job related duties in accordance with the Company's Privacy and Security Policies, which are available on the Company intranet (on the Security Page) and the Internet (under Ethics & Compliance). I further understand that I must sign and comply with this Agreement in order to obtain authorization for access to Confidential Information.

1. I will not disclose or discuss any Confidential Information with others, including friends or family, who do not have a need to know it.
2. I will not in any way divulge, copy, release, sell, loan, alter, or destroy any Confidential Information except as properly authorized.
3. I will not discuss Confidential Information where others can overhear the conversation. It is not acceptable to discuss Confidential Information even if the patient's name is not used.
4. I will not make any unauthorized transmissions, inquiries, modifications, or purging of Confidential Information.
5. I agree that my obligations under this Agreement will continue after termination of my employment, expiration of my contract, or my relationship ceases with the Company.
6. Upon termination, I will immediately return any documents or media containing Confidential Information to the Company.
7. I understand that I have no right to any ownership interest in any information accessed or created by me during and in the scope of my relationship with the Company.
8. I will act in the best interest of the Company and in accordance with its Code of Conduct at all times during my relationship with the Company.
9. I understand that violation of this Agreement may result in disciplinary action, up to and including termination of employment, suspension, and loss of privileges, and/or termination of authorization to work within the Company, in accordance with the Company's policies.
10. I will only access or use systems or devices I am officially authorized to access, and will not demonstrate the operation or function of systems or devices to unauthorized individuals.
11. I understand that I should have no expectation of privacy when using Company information systems. The Company may log, access, review, and otherwise utilize information stored on or passing through its systems, including e-mail, in order to manage systems and enforce security.
12. I will practice good workstation security measures such as locking up diskettes when not in use, using screen savers with activated passwords appropriately, and position screens away from public view.
13. I will practice secure electronic communications by transmitting Confidential Information only to authorized entities, in accordance with approved security standards.
14. I will: Use only my officially assigned User-ID and password (and/or token (e.g., Secura ID card)). Use only approved licensed software. Use a device with virus protection software.
15. I will never: Disclose passwords, PINs, or access codes. Use tools or techniques to break/exploit security measures. Connect to unauthorized networks through the systems or devices.
16. I will notify my manager, Local Security Coordinator (LSC), or appropriate Information Services person if my password has been seen, disclosed, or otherwise compromised, and will report activity that violates this agreement, privacy and security policies, or any other incident that could have any adverse impact on Confidential Information.
17. I will only access software systems to review patient records or Company information when I have a business need to know, as well as any necessary consent. By accessing a patient's record or company information, I am affirmatively representing to the Company at the time of each access that I have the requisite business need to know and appropriate consent, and the Company may rely on that representation in granting such access to me.

Signing this document, I acknowledge that I have read this Agreement and I agree to comply with all the terms and conditions stated above.

Employee/Vendor/Student/Consultant/Office Staff <u>Printed Name</u> *	Facility Name / COID	Date *
	03123	
Employee/Vendor/Student/Consultant/Office Staff <u>Signature</u> *	Business Entity Name	
	College of Nursing	

December 1, 2007

Attachment to IS.SEC.005



Research College of Nursing

Graduate Program Registration Form

Faxed forms will not be accepted.

	Fall
	Spring
	Summer

General Information:	
Student Name:	
Address:	
City:	Undergraduate Student: Yes: No:
Phone:	Email address: *
This is a change of : Address Phone	*Official email will be the Research College of Nursing email address that will be issued when forms are turned in.

Applying for Federal Financial Aid: Yes No

HCA Division Employment:			
Full Time	Yes:	No:	Facility:
Part Time	Yes:	No:	Employee ID #:
(PRN Status does not qualify for tuition discount)			

Course Information: see College website for course offerings www.researchcollege.edu						
Course #	Research College of Nursing Course Name	Credit Hours	On-ground Day / Time	Online	Course Coordinator	Confirm Reg Date Sent
<ul style="list-style-type: none"> • Clinical Requirements are required to be completed before registering for a Practicum course. • See Practicum Course Requirements on College website www.researchcollege.edu. 						

Course #	Rockhurst University * Course Name	Credit Hours	Day / Time	Room	Course Coordinator	Confirm Reg Date Sent
<ul style="list-style-type: none"> • Must complete Separate Rockhurst University Registration Process 						

Student Signature: _____ (date)

Signature or Email Confirmation from Advisor: _____ (date)

For Office Use:	Method of Payment:
Tuition	_____ Check Payable to Research College of Nursing
Late Fee	_____ Mastercard Account #: _____ Exp.Date _____
Deferred Fee	_____ Visa Account #: _____ Exp.Date _____
Total	_____ Discover Account #: _____ Exp.Date _____

Faxed forms will not be accepted.