# NSSHARE User Access Request Form

**for Users in Private Healthcare Organizations**

To request new user access or change access for an existing user, please complete this form. Once the appropriate signatures have been obtained, fax the form to 902-470-7458. **Do not email this form as it contains personal information and email is not secure**. Please allow at least two business days from receipt of the form for the user account to be set up or changes to be completed.

USER IDENTIFICATION: Complete all fields for New Users. Complete fields marked with ⮚ for Existing Users

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| New SHARE Portal User | Existing SHARE Portal User | ⮚ Existing SHARE Portal User ID: |
| New DIS Portal User\* | Existing DIS Portal User\* | ⮚ Existing DIS Portal User ID: |
| \* **NOTE:** This option is for direct access to DIS Portal (for e-prescribing and/or update), not through SHARE Community Med Profile Tab (view only) | | |

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| ⮊ **NOTE:** User’s First Name, Middle Name, and Last Name are **MANDATORY.** If a Middle Name does not exist, please write the word “none”. | | | | | | | | | | | | |
| ⮚ Last Name: |  | | | | | | | | ⮚ First Name: | | |  |
| ⮚ Middle Name: |  | | | | | | | | Preferred or Nickname: | | |  |
| ⮚ Position Title: |  | | | | | | | | | | | |
| ⮚ Healthcare Organization Name: | | | | | |  | | | | | | |
| ⮚ Organization’s Main Address: | | | | | | Street Address | | | |  | | |
| Suite | | | |  | | |
| City/Province | | | |  | | |
| Postal Code | | | |  | | |
| ⮚ User’s Primary Location Address  (if different from above): | | | | | | Street Address | | | |  | | |
| Suite | | | |  | | |
| City/Province | | | |  | | |
| Postal Code | | | |  | | |
| ⮚ Work Phone #: | |  | | | | | | | | ⮚ Work Email Address: |  | |
| Enter user’s Professional Designation information below exactly as it appears on their professional license. | | | | | | | | | | | | |
| Registration Number: | | | | | | | | | Name: | | | |
| ⮊ Alternate User IDS – if the user has any of the following IDs they **must** be provided: | | | | | | | | | | | | |
| PHIM ID(s): | | | | SAP User ID: | | | | | Meditech ID: | |  | |
| Active Directory ID**\*\***: | | | | | **(\*\*** Examples of Active Directory IDs are the IDs used to sign in to XERO, NSES and NSHA/IWK Single Sign On.) | | | | | | | |
| **SHARE PORTAL - PROVIDER AND USER GROUP PROFILE:** | | | | | | | | | | | | |
| 1. **What is the user’s role for which SHARE Portal access is requested?** (For view-only access to SHARE) | | | | | | | | | | | | |
| Physician  Resident | | | | | | | Nurse Practitioner  Midwife | | | | Community Pharmacist | |
| Administrative Role: | | | Worklist Creation (Admin 1) | | | | | Chart Prep (Admin 2) | | | Chart Prep – DIS Only (Admin4) | |
| Clinical Role (CLINIC). Check appropriate role below: | | | | | | | | | | | | |
| Registered Nurse  Licensed Practical Nurse  Registered Dietitian | | | | | | | Occupational Therapist  Physiotherapist  Respiratory Therapist | | | | Lab Technologist  Psychologist  Social Worker | |
| 1. **Does the user require access to NSHA’s Electronic Legal Medical Record for Central Zone, contained in Horizon Patient Folder (HPF) via SHARE?**  Yes  No | | | | | | | | | | | | |

**SHARE User Access Request Form – Page 2**

User Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DRUG INFORMATION SYSTEM PORTAL - PROVIDER AND USER GROUP PROFILE:**

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| (This section is for add/update/e-Prescribing access to DIS Portal. Note: Registered Nurses will not have access to e-Prescribing.)   1. **If DIS Portal access is requested, what is the user’s role for which DIS Portal access is requested?** | | |
| Physician  Midwife  Nurse Practitioner  Registered Nurse | Dentist  Dental Hygienist  Optometrist |  |

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| **ACCOUNT DETAILS:** | | |
| Check one below (Standard, Time Limited, Reactivate, Deactivate, Change of Name, or Change of Access): | | | | | |
| Standard access (no expiry)  Please fill in a start date  Start Date (YYYY-MM-DD): | | | | Time Limited (temporary employment)  Please fill in start and stop date  Start Date (YYYY-MM-DD):  Stop Date (YYYY-MM-DD): | |
| Reactivate Access:  SHARE Portal  HPF via SHARE  DIS Portal | | Start Date (YYYY-MM-DD): | | Deactivate Access:  SHARE Portal  HPF via SHARE  DIS Portal | Stop Date (YYYY-MM-DD): |
| Change of Name | From: | | | To: | |
| Change of Access | Reason: | | | | |

**STATEMENT OF ACCEPTANCE AND APPROVAL:**

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| **I declare that:**   1. I have reviewed and confirm the information in the PROVIDER AND USER GROUP PROFILE is accurate; 2. this user is authorized to access patient information available through SHARE in order to fulfill the requirements of his or her role in providing or supporting patient care; 3. this user has signed the SHARE Remote Access Terms of Use Agreement form and; 4. this user has completed, signed and faxed the applicable Challenge and Response form, which I have signed.   **I understand that providing access to remote users and devices exposes the nshealth.ca network to certain security risks. I accept responsibility for the risks imposed by this remote user. I agree to notify the User Access Control Group when this account is no longer needed so that remote access can be disabled.** | | |
| **Individual with authority to sign on behalf of organization: (Please Print)** | **Signature** | **Date Signed** |
| **Name:**  **Title:** | **X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Date (YYYY-MM-DD)** |
| **Work Phone #:** | **Work Email:** | |

NSSHARE Remote Access/Terms of Use Agreement

**User Name (please print) Title**

**Clinic or Organization Telephone Number**

All references to SHARE include access to NSHA’s Electronic Legal Medical Record for Central Zone, contained in Horizon Patient Folder (HPF) via SHARE, as applicable. In consideration of receiving access to SHARE , the SHARE remote user (the “user”) agrees to the following obligations:

1. The user agrees to complete the mandatory training modules as required by the SHARE Program and NS Health and Wellness, for example:

* *SHARE Portal Users:* SHARE Privacy Zone and SHARE Fast Track Modules
* *HPF via SHARE Portal Users:* HPF Module
* *Community Med Profile (DIS) via SHARE Users:* DIS Module 3 – Privacy and Access, and Community Med Tab – DIS Getting Started Guide
* *DIS Portal Users:* DIS Module 1 – Introduction to the Drug Information System, DIS Module 2 – Functions, DIS Module 3 – Privacy and Access, and DIS Portal Users – Getting Started Guide

1. The user has read the SHARE Privacy and Security Policy and understands their obligations including, but not limited to, (refer to the SHARE Privacy and Security Policy for a complete list of obligations):

* The user shall only access SHARE in the performance of the user’s role within the health care system; specifically when they have a care relationship with the patient and the information is necessary for the provision of health care;
* Access to SHARE outside of the provision of care will be treated as a privacy breach;
* The user is only permitted to print information from SHARE for the purposes of providing health care;
* The user shall take reasonable precautions to ensure that information printed or being viewed from SHARE is not visible to any person without authorization to view the information;
* No user shall reveal their password to another person, or allow it to be accessible to another person nor shall they allow another person to access SHARE information using their password. The user agrees that sharing passwords is in violation of this Agreement and may result in termination of access privileges;
* The user shall immediately report any breach or suspected breach of privacy or security to the organization’s Privacy Officer;
* The user must notify the information services support provider of any potential duplicate patient records they identify in SHARE;
* The user will be held accountable for any misuse of SHARE access and/or privileges. Any user found to have violated provisions within this policy and/or any other relevant policies and agreements may be subject to suspension or termination of SHARE access privileges and disciplinary action;
* The user understands that the DHW has the authority to audit and monitor all access to SHARE at any time without notice or warning;
* The user shall not access SHARE outside of Canada without express prior written permission from the Minister of Health and Wellness;
* If accessing HPF via SHARE, the user is aware of all NSHA’s policies applicable to HPF relating to privacy, confidentiality and security. These policies are available at <http://policy.nshealth.ca/Site_Published/DHA9/dha9_home.aspx>: [CH 30-100 Privacy](http://policy.nshealth.ca/Site_Published/DHA9/policy_details.aspx?policyDetails.QueryId.Id=42369) and Confidentiality of Personal Health Information (PHI), [CH 05-015 Computer Password](http://policy.nshealth.ca/Site_Published/DHA9/policy_details.aspx?policyDetails.QueryId.Id=30518), [CH 05-020 Computer End-User Acceptable Use](http://policy.nshealth.ca/Site_Published/DHA9/policy_details.aspx?policyDetails.QueryId.Id=30266) and [CH 05-070 Remote Access](http://policy.nshealth.ca/Site_Published/DHA9/policy_details.aspx?policyDetails.QueryId.Id=30929).

1. For users with access to the Personal Worklist screen in the SHARE Portal:
   * The user may enter only non-urgent administrative information related to follow-up of patients in the Notes field
   * The user is not authorized to enter urgent information, clinical information, or information related to clinical decisions in the Notes field because the Notes are not saved once a patient is deleted from the Personal Worklist.
2. The terms of this Agreement continue after termination of this Agreement.
3. This Agreement shall be governed by the laws of the Province of Nova Scotia.

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| **To demonstrate their agreement**, the parties have signed below. **User:**  Name (Print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Individual who has authority to sign on behalf of the private healthcare organization**:  Name (Print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |