

Attention: \_\_\_\_\_

Log#: \_\_\_\_\_

## Capital District Health Authority Challenge Response Form

**No passwords will be reset without successfully answering a minimum of 3 different questions when calling the IT Helpdesk!!!**

**Required For Every Password Reset within CDHA.**

**(Please Print Clearly)**

**Please do not use any Acronyms / Abbreviations when filling out this form.**

<b>Last Name:</b> (Name you are know as)	(Legal) <b>Given Name:</b>	<b>Middle Initial:</b> _____ (If no middle name, enter N/A)
<b>Preferred Name:</b>	<b>Program/ Dept.:</b>	<b>Work Phone:</b>
<b>Site:</b>	(No Acronyms) <b>Building:</b>	<b>Other Optional Phone:</b>
<b>Position:</b>	<b>Floor:</b>	<b>Room:</b>

**NOTE: Your receipt of the Challenge Response Form from the CDHA ITS Department verifies your authorization to access, input, and/or update, data within the Capital District Health Authority Network and its computers and/or devices.**

**I acknowledge acceptance of User-ID and Password and clearly understand that:**

- 1) I will not attempt to access information from the system by using a User ID other than my own.
- 2) I will not disclose my password or account information to anyone, under any conditions or circumstances.
- 3) I will not gain access to the system with my User-ID and password and then allow another person to enter or retrieve data from the system.
- 4) I will not attempt to learn another users' password.
- 5) I will not install or remove any software or hardware.
- 6) I will not attempt to access any unauthorized data or applications.
- 7) If I have reason to believe that the confidentiality of my password has been broken, I will follow the appropriate procedure for changing my password and notify Information Technology Communication Services.
- 8) If I can access a software application or data that I know I should not have access to, I will immediately notify Information Technology Communication Services.
- 9) I understand that all information to which I have access is strictly confidential and I will not discuss it other than work related items. The privacy of health related information must be maintained at all times.
- 10) Any devices(i.e. Black Berries, laptops) that connect to the CDHA data network and has CDHA information on it will have CDHA approved encryption software installed and operational on it.
- 11) My account may be accessed with appropriate approval by notify Information Technology Communication Services.
- 12) I understand the CDHA has the right to monitor access and usage of my account.
- 13) I will abide by all hospital policies and procedures relating to the use of computer equipment and access of information through the use of computer technology.

I understand that my User-ID and password combination **ARE NOT TO BE SHARED WITH ANYONE AND I AM ACCOUNTABLE FOR ALL ACTIONS PERFORMED RESULTING FROM THE USE OF MY SPECIFIC IDENTIFICATION.** A breach of any of the above may result in disciplinary action being taken by my employer and up to and including termination.

**EMPLOYEE DECLARATION:**

I read and understand this document. I acknowledge that I have been assigned a User-ID and password for my sole use and that the following information will be used to identify me when I request a new password, or a password change.

Please answer the following questions to be used for password verification. **(Please Print Clearly)**

Last 4 digits of Driver's License: (Her Last Name before Marriage)	(N/A only if you do not have one) <b>This field is Mandatory!</b>
Mother's maiden Name:	Your middle name:
Please pick at least one. What is your favorite color?:	Your date of Birth (DD/MM):

**Employee Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Supervisor Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

Please fill out entire form and fax to the ITUSERIDS  
Please remember to have your manager sign the form

**Fax#: 473-8353**

Revised May 06, 2010