Maryland Department of Health and Mental Hygiene

Prevention and Health Promotion Administration

Center for Cancer Prevention and Control

**CRF/CPEST Database Access Request Form**

**INSTRUCTION SHEET**

In order to receive access to the CRF/CPEST Client Database (CDB) and/or Educational Database (EDB), potential users must obtain a database user account which is created and maintained by the Surveillance and Evaluation Unit (SEU). In order to submit a request please read the following instructions carefully, complete the CRF/CPEST Database Access Request Form, and provide documentation illustrating an understanding of DHMH and CRF/CPEST data access policies (more information below). Individuals seeking to deactivate, reactivate or modify an existing database user account should only submit a CRF/CPEST Database Access Request Form.

**How to complete the CRF/CPEST** **Database Access Request Form (found on page 2):**

**Step 1:** Select the purpose of request from the options provided.

**Step 2:** Indicate which database(s) you need to access (e.g. CDB or EDB).

Note: The CRF/CPEST databases serve different purposes. The CDB is used to capture information about cancer screening, diagnosis and treatment, and patient navigation, while the EDB is used to capture cancer outreach, education, and publications. Determine which database(s) need to be accessed, and select from the database options provided.

**Step 3 (For CDB access only):** The CDB is designed to allow varying levels of access, which are assigned based on CDB user needs. Please review the access levels in the table below and indicate which access level you are requesting. Users may choose from one of five access levels. Existing users may request a modification of their account, should they need to change CDB access level. Please provide clear and concise justification for the request in the space provided (e.g., a clinical nurse manager seeking Level 5 access to pull client records and conduct quality assurance checks of clinical data entered).

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **CDB Access Level** | **CDB User Needs** | | | | |
| View identifiers+ | Add/update data | Print labels/letters | Download data file with identifiers+ | View reports without identifiers |
| **Level 5: Data Manager\*** | *X* | *X* | *X* | *X* | *X* |
| **Level 4: Data Enterer\*** | *X* | *X* | *X* |  | *X* |
| **Level 3: Case Manager\*** | *X* |  | *X* |  | *X* |
| **Level 2: Analyst** |  |  |  |  | *X* |
| **Level 1: Reports User** |  |  |  |  | *X* |

\*These levels provide access to confidential data: your program and personnel must follow HIPAA, state law, and local policies/procedures to protect data

+Identifiers include demographic information attached to the client’s confidential medical information (e.g. name, address, and date of birth).

**Step 4:** Enter the contact information for the individual seeking database access. Both new and existing users must provide this information.

**Step 5:** Review and sign the Database Access Request Form, DHMH policy documents (see bulleted list of policies below), CDB Confidentiality agreement, and Combined OIT Policy Acknowledgement Form below.

* Review the attached CDB Confidentiality Agreement (**Note: Only those seeking CDB access should review and sign this**)
* Review the following DHMH policies:
  + DHMH Electronic Information System Policy 02.01.01: <http://dhmh.maryland.gov/docs/02.01.01%20EITS%2010-16-13.pdf>
  + DHMH Software Policy 02.01.02: <http://dhmh.maryland.gov/policy/02.01.02%20Sofeware%20Copyright%206-5-98.pdf>
  + DHMH Information Assurance Policy 02.01.06: <http://www.dhmh.maryland.gov/SitePages/summary.aspx>
* Using **blue** ink, provide original signatures on the CRF/CPEST Database Access Request Form, the CDB Confidentiality Agreement, and the DHMH Combined OIT Policy Acknowledgement Form (found on pages 2-4, below).
* Mail the signed documents to: **Maryland Department of Health and Mental Hygiene**

**Center for Cancer Prevention and Control**

**Surveillance and Evaluation Unit**

**201 West Preston Street, Room 406A**

**Baltimore, MD 21201**

Maryland Department of Health and Mental Hygiene

Prevention and Health Promotion Administration

Center for Cancer Prevention and Control

**CRF/CPEST Database Access Request Form**

**PURPOSE OF REQUEST:**

Create User Account Deactivate User AccountModify User Account  Reactivate User Account

**DATABASE ACCESS REQUESTED:**

Client Database (CDB)  Education Database (EDB)

**ACCESS LEVEL/ROLE REQUESTED (FOR CDB USERS ONLY):**

|  |  |  |
| --- | --- | --- |
| **Access Level/Role** | **Check Box (please check only one box)** | **Justification for Request** |
| Data Manager |  |  |
| Data Enterer |  |  |
| Case Manager |  |  |
| Analyst |  |  |
| Reports User |  |  |

Level/DB USERS ONLY) (cTED: R RETURNING USERS:mission descriptions? There seems to be some overlap/redundancy.

**CONTACT INFORMATION FOR NEW OR RETURNING USERS:**

|  |  |  |
| --- | --- | --- |
| First Name | MI | Last Name |
|  |  |  |

|  |  |  |
| --- | --- | --- |
| Agency/Program | | County |
| Address Street | | Room |
| City | State | Zip Code |
| Email | | Phone Number |
| Connected to DHMH Network Yes  No | | |

**Signature of User \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of User’s Supervisor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**For CCPC/SEU Use Only:**

Local user access  State user access

**Approved by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Maryland Department of Health and Mental Hygiene**

**Center for Cancer Prevention and Control (CCPC)**

**Client Database (CDB)**

**CONFIDENTIALITY AGREEMENT**

I, , understand that as part of the Cigarette Restitution Fund (CRF) Program, Cancer Prevention, Education, Screening and Treatment (CPEST) Program, I will be working with confidential information contained in the Client Database (CDB). I also understand that the confidentiality of this information is established by Md. Code Ann., Health-General §§4-101 to 4-103 and that a person who uses or discloses this information is in violation of these statutes and is subject to the legal penalties set forth therein.

I understand that I am responsible for protecting the confidentiality of information pertaining to individuals receiving cancer services as contained in the CDB, including but not limited to a person’s address and/or other identifying information and medical information. I agree to keep this information confidential.

I also understand that this information may be used only for purposes directly related to the CRF/CPEST Program and that no person who is not engaged in this specific program may have access to this information.

I understand that the CDB shall not be used in a public place or on a public computer and shall be accessed at a worksite approved by the user’s supervisor, and I agree to comply with the CPEST CDB Policy.

## Acknowledgement and Signature

I have read and understand the above Confidentiality Agreement and agree to treat confidential information accordingly.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Typed or Printed

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Title

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Institution or Organization

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date

**Maryland Department of Health and Mental Hygiene**

**Information Technology Security Policy,**

**Standards & Requirements**

COMBINED OIT POLICY ACKNOWLEDGMENT FORM

|  |  |  |  |
| --- | --- | --- | --- |
| **This document is a combined policy acknowledgment form for DHMH computer-related policies. Following consultation with your supervisor, please read and initial the appropriate acknowledgment sections, then sign the signature block below.** | | | |
| **Acknowledgement Section- Initials** | | **Policy Number-Statement** |  |
| Employee | Supervisor | **02.01.01 DHMH Information Technology Security Policy**  Policy, Standards and Requirements for the protection of Information Technology. I hereby acknowledge awareness of DHMH Policy 02.01.01, and that my use of these systems constitutes my consent to comply with this directive. | |
|  |  |
|  |  | **02.01.02-Software Copyright Policy & the State of Maryland Software Code Of Ethics-**  Unauthorized duplication of copyrighted computer software violates the law and is contrary to the State's  standards of conduct. The State disapproves of such copying and recognizes the following principles as  a basis for preventing its occurrence.  **1. The State will not permit the making or using of unauthorized software copies under**  **any circumstances.**  **2. The State will provide legally acquired software to meet its legitimate software**  **needs in a timely fashion and in sufficient quantities to satisfy those needs.**  **3. The State will enforce internal controls to prevent the making or using of**  **unauthorized software copies, including measures to verify compliance with these**  **standards and appropriate disciplinary actions for violations of these standards.**  I understand that making or using unauthorized software will subject me to appropriate disciplinary  action. I understand further that making copies of, or using unauthorized software may also subject me  to civil and criminal penalties. **My signature below indicates that I have read and understand Policy**  **02.01.02- Software Copyright Policy and the State of Maryland Software Code of Ethics**. | |
|  |  | **02.01.06-Policy to Assure Confidentiality, Integrity and Availability of DHMH Information (IAP)**  I acknowledge that I am required to comply with the general applicable sections of this policy as it  relates to my current job duties. I further acknowledge that should I breach this policy, I am subject to  disciplinary, civil, and criminal consequences.  **02.01.06-IAP–*“Specific Personnel” Acknowledgement [ ] Check here if this applies.***  If I am currently designated, or at any time my job duties require me to be designated as a  Custodian, Data Steward, Designated Responsible Party, Database Administrator, and/or Network  (System) Administrator, I acknowledge that I am required to comply with the corresponding  responsibilities assigned to ***specific personnel***. Likewise, if I am currently required, or if at any time my duties include the requirement for preparation or monitoring of contracts or memoranda of understanding, I acknowledge that I am required to comply with the ***specific personnel*** provisions of the Information Assurance Policy and guidance. | |

|  |  |  |
| --- | --- | --- |
| Employee/User Signature Block- I hereby acknowledge that I have reviewed and understand the above-initialed policies. | | |
| Employee/User Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| Employee/User Identification (Please Print) | NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  PIN # or CONTRACT#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | AGENCY/COUNTY:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ADMINISTRATION/UNIT:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ LOCATION:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Supervisor’s Verification | Supervisor Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_ | °Supervisor verifies that the employee/user has acknowledged and initialed the appropriate policies for his/her position. |
| **DHMH 4518 (REV Nov 2010)** This form will be retained in the employee’s DHMH personnel file. | | |

All pertinent policies can be accessed and read at <http://www.dhmh.maryland.gov/SitePages/op02.aspx>

and State IT Security policy <http://doit.maryland.gov/Publications/DoITSecurityPolicy.pdf>