THE UNIVERSITY OF TEXAS MEDICAL BRANCH AT GALVESTON INFORMATION RESOURCES SECURITY ACKNOWLEDGMENT AND NONDISCLOSURE AGREEMENT

Office of Regional Medical Education - Community Preceptors

Ensuring the security and integrity of the University of Texas Medical Branch at Galveston's information and information resources is the responsibility of all UTMB faculty, students, staff, and others who may use its information resources. The importance of protecting the reliability and accuracy of these information resources cannot be over emphasized. UTMB's academic, business, clinical, and research functions have become increasingly dependent on automation to access, process, store, and transmit information. The success of this university's missions depends on this information. The security and integrity of this information depend on each of us.

UTMB calls on all faculty, students, staff, and others who may use its information resources to fulfill the obligation of protecting these valuable information resources.

1. I understand and agree to abide by the following:
   a. ANY information concerning ANY person, system, or asset of UTMB that is obtained while performing my duties is of value to this university and may be confidential or sensitive, regardless of medium. I will NOT disclose any information to any individual, unless such release of information is directly related to the performance of my responsibilities.
   b. ALL passwords to information resources including, but not limited to, mainframe applications, network systems, voice mail, copy machines or long distance telephone use that I receive or devise are confidential and are to be used only by me. I will NOT disclose to any unauthorized person any password(s) I am given or devise and I will NOT write such password(s) or post them where they may be viewed by unauthorized persons. Use of a password not issued specifically to me or to a group of which I am a member is expressly prohibited. I am responsible for all transactions performed as a result of access authorized by use of my password.
   c. I will NOT attempt to circumvent the computer security system by using or attempting to use any transaction, software, files or resources that I am not authorized to use.
   d. I will NOT alter or in any way change information except in the performance of the duties of my job.
2. I understand and will comply with all policies, standards, and procedures adopted to safeguard information and associated information resources. Further, I acknowledge that I have received, read and understand the security policies outlined above and in the Information Resources Security Manual: http://intranet.utmb.edu/sacs/report/Sources/SACS_3_9_2_11.pdf
3. I understand that failure to comply with any of the conditions noted herein may result in my being disciplined or terminated from my position, and/or contract. I further understand that the university retains the right to pursue prosecution when misuse of its information and/or information resources is suspected.
4. To ensure data confidentiality, integrity and authorization, no person, unless specifically authorized in writing by the data owner, shall remove, copy, print, or cut and paste sensitive data from any UTMB information system.

Sign agreement and fax to: ORME at (409) 772-6565

My signature below represents my acknowledgment that I have received, read, and understand the security policies as outlined in the Information Resources Security Manual.

PRINT	
	LAST NAME: FIRST NAME: MI:
	****4 Digit PIN Number:**
	Date of Birth:
	Sponsoring UTMB Department: Office of Regional Medical Education (**ORME9999**)
	Company Name (if applicable):
	Job Title:
	Contact/Office Phone:
	Return Login Info. to either: ☐My Email address: ☐My Fax:
	Start Date: JULY 1, 2008
	End Date: **JULY 1, 2009**

Applicant Signature: **Date:**

*** You will use this number during the initial login process so that you can create your own password. Please be sure to choose a 4 digit PIN that you will remember. If you have a **UTMB faculty appointment**, the last 4 digits of your social security number are required here.*

For office use only:

My signature below represents that I confirm this user's access is appropriate and that there is a continued need to maintain access permission.

TR LAST NAME:	FIRST NAME:	MI:
TR Signature:		