

## Mobile Device Active Sync Agreement

<b>Confidentiality and HIPAA Security</b>	I agree to take all the necessary measures to securing the device's data as stated in SVHC's Confidentiality Statement and policy. If the information should be compromised because of my own actions or omissions I may be subject to corrective action. <a href="#">Confidentiality of Information</a>
<b>Data Plan and Phone Support</b>	I have an unlimited data plan with my personal wireless provider and will be responsible for all associated network charges. SVHC is not responsible for any personal wireless data/voice plan or charges. SVHC is not responsible for the replacement of a device owned by me and lost during the term of my employment. I agree that SVHC is not responsible for phone maintenance, repairs or wireless network service including any additional charges for use of the cellular service.
<b>Device</b>	A mobile device (iPhone, iPad, iPod Touch, Droid but not limited to).
<b>Loss of Data and Applications</b>	I agree that SVHC is not responsible for phone maintenance, repairs or wireless network service including any additional charges for use of the cellular service.
<b>Lost or Stolen Device</b>	I agree to immediately call the IS Help Desk at 447-5411 to report the loss. IS will perform a remote wipe of the device.
<b>Remote Wipe</b>	The removal of all applications and data from the device, returning it to the original factory defaults (phone calls can still be made).
<b>End of Employment</b>	Upon the notification of the employment termination; the IS department will perform a remote wipe of the device. If the device is owned by SVHC it will be returned.

**Requester** - I have read and agreed to the above conditions and understand that if I fail to follow the recommended guidelines; I could be held liable for damages caused by negligence.

- Physician/Provider     
  Member of Executive Mgt. Team (EMT)     
  Department Director/Supervisor  
 Direct Care Provider     
  Information Systems Staff (IS)     
  Other:

Type of Device:

**Requester Printed Name**

**Signature**

**Date**

### President/Vice-President/Chief Medical Officer/Director/Provider

Is this employee exempt?       Yes       No      (Not applicable to private offices)

If non-exempt, you are aware and approve that the employee will be compensated for work completed while using this remote access token? \_\_\_\_\_ (please initial)

**Approver Printed Name**

**Signature**

**Date**

### Human Resources

\_\_\_\_\_

**Approver Printed Name**

\_\_\_\_\_

**Signature**

\_\_\_\_\_

**Date**

***Please return to the Information Systems Helpdesk***

### For Office Use Only

\_\_\_\_\_

**IS Staff Printed Name**

\_\_\_\_\_

**Signature**

\_\_\_\_\_

**Date**