ST. MARY'S HEALTH CARE SYSTEM
1230 Baxter St. | Athens GA 30606-3791 | (706) 389-3000 | www.stmarysathens.org

# Electronic Documenting System Training Statement

I, _____ _____, agree not to use any assigned
(**PRINT YOUR FULL FIRST, MIDDLE & LAST "LEGAL NAME"**)

electronic Documentation system login and password until I have received the proper training. I agree to never share any assigned login and password, nor allow anyone to document using my login and password. I am also aware that random access audits may be performed on students. I understand that I am responsible for all work performed and all information viewed using my assigned login and password.

_____ _____
(Date) (Signature)

_____
(Last 4 digits of social security number)

_____ _____
School/Program Name Preceptor/Sponsoring Physician

**** Note, sign this form ONLY if your sponsoring physician requests that you have access to view information in the electronic medical record.

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For GME, Clinical Education, or Pharmacy Office Use Only:

Approved Access Dates: _____ through _____

Completed by: _____ _____
(Staff initials) (Date)