

Department of Medical Imaging
The Royal Children's Hospital

FUJI SYNAPSE
USER ACCOUNT APPLICATION FORM

All sections must be completed – Incomplete applications will not be processed.

You must have an **Individual Windows Logon** to access FUJI SYNAPSE
I don't as yet have an Individual Windows Logon?

Please apply using the application form on this link:
<http://www.rch.org.au/emplibrary/it/WindowsLogonForSynapse.DOC>

If you are unsure as to whether you already have an Individual Windows Logon please contact the Service Desk on x6277

FIRST NAME	SURNAME	
EMPLOYEE NUMBER	POSITION	
DEPARTMENT		
IF ON A FIXED TERM CONTRACT, WHAT IS THE LAST DATE OF YOUR EMPLOYMENT?		
EXT/PAGER #	FAX	EMAIL <small>(must be an RCH email address)</small>

State the reason you require access to the FUJI synapse

What is the username of your individual windows login? _____

NB: Authentication is verified using your windows login password. There is no need for synapse to store any passwords.

Responsibilities of users

As a user of the FUJI synapse you are required to understand and accept the following responsibilities:

- You are bound by the hospital confidentiality policy. http://www.rch.org.au/policy_rch/index.cfm?doc_id=6354
- You must not divulge your password to any person
- You must not use your username & password to give access to any other person
- You are required to log off when you have completed your task. You should not leave an active screen unattended
- Access to the synapse should only be made on a 'needs-to-know' basis and/or for patients for whom you are a caregiver
- Notification of creation of synapse user accounts will ONLY be sent to internal hospital email addresses

I agree to abide by the confidentiality guidelines as set out above and realise that the release of information to unauthorised persons is strictly forbidden.

Signed _____ Date _____

ALL applicants MUST have the following section completed by their DEPARTMENT HEAD (or delegate).

I acknowledge that access to the synapse is necessary for the above applicant in the course of his/her normal duties.

Signed _____ Date _____
(Department Head)

Print name _____

Please forward to: The PACS Administrator, Medical Imaging Department Phone 9345 5401 Fax 9345 6694