



VENDOR VPN ENROLLMENT FORM

Information Systems - Account Administration

Fax: (617) 724-8314

Your Company:	Contact at PHS/Department:
First Name: MI:	Last Name: MM/DD of Birth (required for password change mgmt.)
Partners Username:	E-Mail Address:
Manager:	Preferred phone number or last 4 digits of SS#: (Required - if you need a Partners Username)
Mailing address:	PC or MAC: If PC please indicate Operating System: (2K, XP):

Guidelines:

- Use of the Partners network through a VPN account is intended solely for the individual whose signature appears on this form. No unauthorized users residing at the authorized user's residence or place of business are permitted to use the client software at any time.
- Client software is kept in possession of the authorized user only. The authorized user must not distribute client software to any other person or persons.
- Users must be physically present at the console of the device (computer) that has the VPN software installed when initiating VPN connections to Partners. The user will disconnect an active VPN connection, when he or she steps away from the device. Devices that have an active connection to the VPN switch must never be left unattended.
- Partners HealthCare has the right to revoke the privileges of the VPN account at any given time if these guidelines are not followed.
- The user will comply with the Partners standards for VPN access and make changes when advised to do so. This includes, but is not limited to the following: policy changes, software updates or patches, encryption methods and authentication methods.

Agreement: I hereby request that a VPN Account be issued to me and agree to use the remote connection for business purposes only and only to the systems for which I have been authorized. In order to preserve the integrity of this data, I agree to adhere to all the requirements outlined in the **Guidelines** section of this document. I understand that if I violate any of these terms, I will be subject to disciplinary action up to and including termination from my employment with Partners HealthCare System (if applicable) and criminal prosecution.

I agree to pay **\$75.00** for any SecurID card issued to me which is lost or damaged. Please make the check payable to **Partners Health Systems, Inc. One Constitution Center, 2nd Floor Charlestown, MA 02129 attn. Remote Access Admin.**

Signature of Requestor: _____ **Date:** _____

Authorization: **I authorize the above-named requestor to gain access in to the Partners private network.**

If the SecurID card is lost, stolen, or damaged, a \$75.00 non-refundable fee to cover the cost of the SecurID card is required from each consultant/contractor and vendor. Please make the check payable to **Partners Health Systems, Inc.** and mail to **PHS-Account Administration, One Constitution Center, 2nd Floor, Charlestown, MA 02129 attn. Remote Access Admin.**

_____ **Print name of Contact's Department Head, Chief or Director** _____ **Signature** _____ **Date** _____ **Phone number**