



**Title: Access Control Guidelines (For Computer-based Codes)**

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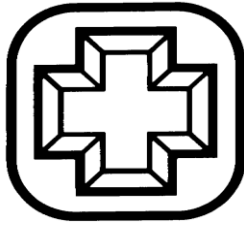
**Rationale:** To provide a means of issuing access cards or pin codes through the use of computer-based access codes.

**Policy:** The responsibility of safe guarding equipment and people is a responsibility shared by all employees, staff and visitors, who work, manage and utilize services within the hospital. The Security Services Department monitors and randomly audits the use of access methods. Failure to adhere to the Access Control Guidelines may result in disciplinary action up to and including termination of employment, business privileges or, banned from hospital property.

**Procedure:** The following Guidelines have been prepared to protect occupants and property from unauthorized entry, misuse or evasion of computer-based access cards and pin codes:

1. Attempts will not be made to gain entry into security controlled area without proper authorization.
2. All requests for access or ID cards must be directed to Security Services. Security Services will provide the appropriate application to the supervisor/manager of the requested department, facility, or business within the North Mississippi Health Services System.
3. Security Services will not grant access without the Unit/Facility supervisor/manager authorization. If an access card is lost or stolen, notify Security immediately so that the card can be suspended. Replacement cards are \$20.00, due upon receipt of the card.
4. Access control cards and pin codes must be kept confidential. Disclosing one's access code to another, or using the pin code of another to gain entry into an area, is a breach of security and a violation of North Mississippi Medical Center's Secure Environment Policy. Violations may result in the revocation of cards and pin codes, termination, barring from the properties of NMHS and possible criminal charges being sought.

**Distributed To:** Bruce Ridgway  
**Issued Date:** Nov 1995  
**Reviewed Date:** Oct 2001, Feb 2002, Mar 2013  
**Revised Date:** Jan 1996, 1997, Mar 1998, Feb 2002, Jan 2009, Mar 2013



North Mississippi Health Services  
Security Badge Access Form

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Alternate phone: \_\_\_\_\_

Email: \_\_\_\_\_

What kind of experience is this? Check one:

- Shadowing (observing only)  
 Clinical practice (hands on, skills practice)  
 Volunteer

What is your start date and end date for this clinical experience?

Start: \_\_\_\_\_ End: \_\_\_\_\_

*For student use only:*

School Name: \_\_\_\_\_ School Phone: \_\_\_\_\_

Program: \_\_\_\_\_ Instructor Name: \_\_\_\_\_

Preceptor Name (if known): \_\_\_\_\_

What facility will you be located?

What area/unit will you be located?

NMMC Tupelo

NMMC Eupora

NMMC Iuka

NMMC Pontotoc

NMMC West Point

NMMC Hamilton

NMMC Clinic (name of clinic) \_\_\_\_\_

Is this required for educational credit?

Yes  No

If yes, does your school identification badge have your picture on it?

Yes  No