Application for Obtaining Password Protected Information

In order to obtain information from password protected electronic storage media of the University of Connecticut Health Center; this form must be completed and signed by the Requestor, the user’s Supervisor, the Director of Labor Relations, and then submitted to the Vice President for Health Affairs.

Section I

Name of User ____________________________________________ Department ______________________

Name of Requester ______________________________________ Department ______________________

Section II – Access to the following stored information is requested:

Description of Information ________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Describe the efforts made by the applicant to obtain the information from the user or provide detailed justification for not informing the user of request.
____________________________________________________________________________________
____________________________________________________________________________________

Section III – Nature of the Request:

- Copy of electronic mailbox (email) Yes o No o
- Copy of computer contents (hard drive) Yes o No o
- Traffic log of Internet sites accessed (where available) Yes o No o
- Telecommunications Items Yes o No o
- Call Data Records (Calling History) Yes o No o
- Voice Mail Yes o No o

Section IV – Non-Supervisor Originated Request

Does the user’s Supervisor support this request? Yes o No o

If no, why is he/she opposed? __________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

SIGNATURES:

Requestor ______________________________________ Title ______________ Date _____________

User’s Supervisor __________________________________ Title ______________ Date _____________

Director of Labor Relations ________________________ Title ______________ Date _____________

Vice President for Health Affairs ___________________________ Title __________________ Date _____________

Action Approved o Action Rejected o