

# STATEMENT OF PARTICIPATION ELECTRONIC SIGNATURE POLICY COMPLIANCE

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**Program Participant Name** (*print or type*)

I have read and agree to participate in the use of electronic signature to authenticate documents as per the conditions identified in the Electronic Signature Authentication Policy.

I understand that the password and/or PIN assigned to me are confidential. I agree **not** to disclose my password and/or PIN to another person or to permit another person to use it. I further agree **not** to use another's password and/or PIN.

I understand that I am responsible for the content of all resident clinical record entries that I sign electronically.

I understand that failure to comply with policy requirements could result in revocation of the privilege to participate in the Electronic Signature Authentication Program, disciplinary action, termination of employment, and/or loss of medical staff credentials.

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**