

## BYOD Registration Form

Device Owner Name:	
Date:	
Device Description:	
I will be using this personal de may not come into contact wit regarding our clients. To mitig	evice within my work duties and my device may or h PHI and be a source for safety and security issue rate unethical or unsecure behavior, I am king sure it meets the security standards set by ACT
An audit of the device's securit documented below.	ty measures has been performed, and is
Auditor: Name of auditor:	
Primary Intended Use*:	
e-fax, VoIP app, etc.,) or perfor	e services (i.e. email, practice management system, ming practice functions (i.e. calling or texting with ance cards/client info, creating and/or storing
Operating Software Version:	Most Recent Version?: Y / N
Technical Measures (if the tedevice, check N/A):  □ Encrypted (full device) □ N/A	echnical measure is not applicable to your
- Antivirus Active	□ <b>N/A</b>
□ Firewall Active	□ <b>N/A</b>
□ Password is strong	□ <b>N/A</b>
<ul> <li>Set to log out after idle time</li> </ul>	□ <b>N/A</b>

<ul> <li>□ Tracking software is active □ N/A</li> <li>□ Has a user account just for doing ACT Services business □ N/A</li> </ul>		
Backup Strategy For This Device: (or explain why it's not needed):		
The device, as described above, currently satisfies the requirements of ACT Services's policies and procedures, including the Bring Your Own Device Policy: Y $/N$		
If, at a later date, this device will no longer be used in a clinical setting, this device will need to be properly retired from use. This retirement process may include properly removing and verifying that no sensitive information still is held in the device.		
I agree to comply with the policies and procedures of ACT Services with regards to this device, including the Bring Your Own Device Policy. I have read the Bring Your Own Device Policy and understand its contents.		
Signature of Device Owner		