

# North Carolina A&T State University Banner Student User Account Request Form

Instructions: For Student Banner access, submit this **completed** form to the Registrar's Office, Dowdy Building.

Applicant Name: \_\_\_\_\_  
(Last) (First) (Middle)

NC A&T SU E-mail Login: \_\_\_\_\_ Department: \_\_\_\_\_ Phone #: \_\_\_\_\_ Ex. \_\_\_\_\_

Bldg. \_\_\_\_\_ Rm/Cubicle/Floor: \_\_\_\_\_ Job Title: \_\_\_\_\_

Employment Status (check one):  Vendor  Contracted Through Agency  Temporary  Permanent (EPA or SPA)

Access Requested:  Dean/Chairperson  Faculty / Advisor  Other (specify) \_\_\_\_\_

## Confidentiality Security Agreement

If approved, I acknowledge that I will have an account to a North Carolina Agricultural and Technical State University system that provides access to sensitive and/or confidential information. I understand that the account and password assigned to me are for my use ONLY. I will only access, alter, and destroy electronic and printed information in accordance with my job duties. I will provide all the necessary safeguards for information in my care. I will not disclose in verbal, electronic, or in printed format information that I'm not authorized to do so to anyone including but not limited to a University employee, student, vendor, or guest.

In accordance with the Computing and Network Usage Policy (<http://www.ncat.edu/~cit/policies/>), I will not perform an illegal or unauthorized activity(s) that would cause harm directly or indirectly to the University network and/or computer technology. I will not violate state law, federal law, nor University policies. I will report to my supervisor and/or the Aggie HelpDesk any security violation as soon as I become aware of it. I will not copy licensed software or use it except in accordance with established procedures or agreements, nor will I assist others in doing so. I will abide by the Family Education Rights and Privacy Act (FERPA) regarding the confidentiality of student records and the Health Insurance Portability and Accountability Act (HIPPA) regarding the confidentiality of patient medical records where applicable.

Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

Supervisor Name (Printed): \_\_\_\_\_ Phone: \_\_\_\_\_

Supervisor Signature: \_\_\_\_\_ Date: \_\_\_\_\_