HR Supplemental Access Request Form

The Supplemental Access Request Form is required for Adding/Changing Department Reps and/or Managers only.

NOTE: Employee Self-Service is assigned to all employees with a valid FSUID. You do not have to complete a Supplemental Access Request form for Employee Self-Service.

Fax the completed form to Human Resources 850/645-9510.

ACTION: Please check appropriate box**. (If you terminate/change a department/manager in section 1, please also complete section 2)**

Section 1

☐ Add ☐ Change ☐ Terminate/Deactivate ☐ Transfer to Department: (Indicate New Depart Info below)

_____ _____
New Dept Number **New Dept Name**

Employee Name: _____ _____ __ Employee Phone Number:_____
Last First M

FSU ID: _____ OMNI Empl ID: _____ Email: _____

Current Department Number: _____ Department Name: _____

Section 2

☐ CHANGE/ADD Department Manager and/or Department Representative

Change/Add Department Manager and/or Department Rep in OMNI.
(Department Manager CANNOT be the same person as the Department Rep)

Department Number: _____ Department Name: _____

Department Manager Name: _____ _____**OMNI Employee ID: _____**
Last First

Department Rep Name: _____ _____ **OMNI Employee ID: _____**
Last First

EMPLOYEE ACKNOWLEDGEMENT: I acknowledge that I occupy a position of special trust with duties that will bring me into contact with information or information resources that are of value to the Florida State University and that require protection. I further acknowledge that I am required to uphold the policies and procedures adopted to safeguard the information and associated resources that may be entrusted to me or with which I have contact. I agree to report violations of policies or procedures to my supervisor, the Information Security Manager or other person designated the responsibility for handling security violations. Further, I agree to protect my User ID and related passwords from unauthorized use at all times and understand that activity logged to my User ID is my responsibility. **I ACKNOWLEDGE MISUSE OF THIS AUTHORITY COULD LEAD TO DISCIPLINARY OR CRIMINAL ACTION**. Note: Dean/Director/Department Head or designee approval is required.

_____ _____ _____
Employee Name Printed **Employee Signature** **Date**

Form Completed by: _____ _____ _____
Name **Phone** **Date**

DEPARTMENT AUTHORIZATION:

_____ _____ _____
Authorizing Name Printed **Title/Position** **Date**

_____ _____ _____
Signature

SECURITY ADMINISTRATOR AUTHORIZATION:

_____ _____ _____
Signature **Date**

Revised 03/2011