


Application and Authorization for OPSB System Access

Please complete this form to request access to one or more OPSB automated systems, to change authorization for a system(s), or to inactivate (i.e., cancel) authorization for a system(s). The approved user, by submitting and signing this application, agrees to the following:

1. Use of your password in connection with any transaction or submission in a system constitutes your signature, with all the legal effect of any other signature by you, entering your password has the same effect as signing your name.
2. To keep the password that you are assigned confidential and secure at all times; and not to disclose your password to another person or to allow another person to use your password.

Check One: **NEW** **CHANGE** **INACTIVATE**

Effective Date: _____ Previous Incumbent (if applicable): _____

<input type="checkbox"/>	System	Agency Name or Code(s) *	Role(s) <small>Check or Complete</small>	Comments/Other
<input checked="" type="checkbox"/>	Statewide Personnel System (SPS)  <small>STATEWIDE PERSONNEL SYSTEM</small>		<input type="checkbox"/> Agency Benefits Coordinator (ABC)	Check Distribution Code
<input type="checkbox"/>	*Must include <u>exact name of Supervisory Organization</u> where security is to be assigned. ↵			
All Workday Training Required for Role Completed:			Yes: <input type="checkbox"/> No: <input type="checkbox"/>	
<input type="checkbox"/>	Benefits Admin System (BAS)		Agency Benefit Coordinator	Check Distribution Code

USER INFORMATION:

First name:	Last Name:	Signature:
Agency:	Agency Code:	
Agency Mailing Address:		
Phone:	User ID:	Email Address:
Agency HR Director (Authorizing Official):	Name:	Signature:
		Date:

Email completed form to: Shared.services@maryland.gov

FOR DBM SHARED SERVICES/DoIT USE ONLY:

OBSB Authorization:	Date:
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