

AirWatch Request Form

Name	
Email Address	
Username (i.e., tre345)	
iPhone number	
Android Number	

- I have received a copy of the DFM PDA Policy.
- I am using CME funds for the AirWatch license.
- I understand that if my iPad/iPhone/Android is lost or stolen, DFM ITS will remotely wipe all applications and data from your iPad/iPhone/Android.
- I am NOT using CME funds for the AirWatch license (\$30 check payable to UWWMF is required)
- My AirWatch license will be paid by: (Division: i.e., Admin, Madison Residency):
- _____

Signature

Date

Please return this form to the DFM HelpDesk

**UW Medical Foundation
Mobile Device Consent Form**

I, _____ have read the University of Wisconsin Medical Foundation's Appropriate Use and Mobile Device policies and agree to comply with all terms and conditions. I agree that I will make no attempt to circumvent any security mechanisms placed on this mobile device and understand that violation of this requirement may result in suspension of mobile device privileges and/or disciplinary action up to and including termination of employment.

I understand that UW Medical Foundation reserves the right to monitor my use of corporate resources on this device, including e-mail and calendaring, with or without notice, and therefore I should have no expectations of privacy in the use of these resources.

Signed _____

Date _____