



# University of Connecticut Health Center

*A Procedure Guide For Non-Paid Student  
Educational Experiences  
At The University of Connecticut Health Center*



**Prepared by the Department of Human Resources**

**Date: April 2009**

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## INTRODUCTION

The purpose of this manual is to guide you through the procedural steps for non-paid student educational experiences at the University of Connecticut Health Center.

A UCHC non-paid student educational experience is defined as an educational experience that is relevant to the student's current course work or course of study. There are two types of educational experiences at UCHC.

- **Job Shadowing/Observation Experience** is defined as: An individual/student from a "School Sponsored Program" who, as part of their class work, observes clinical/professional services provided at this institution, but does not provide any direct "hands on" care/application.
- **Non-Paid Student Internship** is defined as: An individual/student from a "School Sponsored Program" who, as part of their class work, has an established rotation in a specific UCHC department. There is no payment for these services. This experience is expected to have a "hands on" aspect to it.

In order for a student to participate in a non-paid educational experience at the Health Center, the following criteria must be in place:

- A faculty member from the student's school/university must initiate a request for a student experience.
- All requests for a student placement must be approved by the UCHC department host/preceptor/manager.
- The individual must be enrolled as a student in their school/university.
- The individual's school/university will accept responsibility/liability for the student's educational experience at UCHC through a "School Sponsored Program" contractual agreement.
- All required UCHC documentation and forms must be in place prior to the student starting his/her educational experience.
- Prior to the student starting his/her educational experience, he/she will receive the appropriate compliance/regulatory training needed to fulfill mandated state and federal statutes.

Requests for JDH hospital student educational clinical experiences (i.e. nursing student placement graduate and undergraduate, physical therapy, pharmacy, respiratory therapy, etc.) will be coordinated by the JDH/Department of Staff & Patient Education. You can contact them at: (860) 679-2826.

Requests for any student experiences in UMG or UConn Health Partners will be coordinated by the UMG Clinical Coordinator. The contact number is: (860) 679-2494.

A request for an international non-paid student educational experience at UCHC must go through Jaishree Duggal in Human Resources. She can be contacted at (860) 679-4430.

The content that follows will identify and explain the steps in the process to bring an individual "on board" for a UCHC Non-Paid Student Experience.

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## Bringing A Student “On Board” To Job Shadow/Observe or As A Non-Paid Intern

### Step 1: Request for A Non-Paid UCHC Educational Student Experience

The UCHC host/preceptor/manager is contacted by the student’s/students’ school/university to request an educational experience for a student or group of students.

### Step 2: Required Documentation/Forms

If the host/preceptor/manager agrees to the educational experience, he/she will explain and provide the required documentation and forms to the school/university requesting the student experience.

Required documentation and forms can be found on the UCHC website at this address: <http://employ.uchc.edu/training/learningopportunities.html> then click on Hosting A Non Paid Student Educational Experience. which will take you to this address: <http://employ.uchc.edu/training/hosting.html>

The following documents/forms must be completed by the school/university or student for any educational experience at UCHC.

**Document 1: Student Contract for School Sponsored Program** – this contract outlines the responsibilities and expectations of the affiliating school/university with respect to the student educational experience at UCHC. All contracts can be found at this address: <http://employ.uchc.edu/training/learningopportunities.html> then click on Hosting A Non Paid Student Educational Experience. which will take you to this address: <http://employ.uchc.edu/training/hosting.html>

#### Directions:

- a) Host/Preceptor/Manager obtains two copies of the appropriate contract from the website address above
- b) Host/Preceptor/Manager fills out Pages 1 and last page (on last page “For the Agency” section) on both contracts
- c) Host/Preceptor/Manager mails both contracts to the Affiliating school/university (Affiliate fills out last two pages “Certification” and “For the Affiliating Agency” section)
- d) Affiliate mails both signed contracts to UCHC host/preceptor/manager
- e) If affiliating school/university returns the contracts with any edits or additions, the adjusted contract needs to be approved by the Assistant Attorney General’s Office prior to a senior level manager’s signature
- f) Host/Preceptor/Manager gets appropriate senior level management’s signature on both contracts (Last Page)
- g) Host/Preceptor/Manager places one original signed contract in student’s file, and mails the other original back to the affiliating school/university

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**Step 2 Continued:**

\*\*Please use the appropriate student contract for your area. They are:

- ✓ **University of Connecticut Health Center (UCHC) - Student Contract for School Sponsored Program**
  - ✓ **UMG/Health Partners Student Contract for School Sponsored Program**
  - ✓ **Correctional Managed Health Care (CMHC) Student Contract for School Sponsored Program**
  - ✓ **School of Dental Medicine Student Contract for School Sponsored Program**
  - ✓ **John Dempsey Hospital (JDH) - Student Contract for School Sponsored Program**
  - ✓ **Paramedic Experience/UCHC - Student Contract for School Sponsored Program**
- 
- **Document 2: Form A – Verification of School Held Student Health Records –** this form verifies that student has had the required immunizations/health screenings prior to coming on-site to the Health Center. **Document found in Appendix A**  
**Directions:**
    - a) Host/Preceptor/Manager sends form to the affiliating school/university along with the two contracts
    - b) Affiliating school/university returns signed form to UCHC host/preceptor/manager along with the contracts
    - c) Host/Preceptor/Manager places signed form in student’s file.
  
  - **Document 3: Form B – Confidentiality Policy Statement –** The student acknowledges receipt of this document and signs off that he/she will comply with this policy with respect to holding patient, personnel and organizational information in confidence. **Document found in Appendix B**  
**Directions:**
    - a) Host/Preceptor/Manager has student read and then sign Confidentiality Policy Statement form
    - b) Host/Preceptor/Manager places signed form in student’s file.
  
  - **Document 4: Form C – HIPPA Privacy Student Training Packet -** This training packet includes a review of the organization’s policies and procedures relating to protecting patient information. **Document found in Appendix C**  
**Directions:**
    - a) Host/Preceptor/Manager has student read packet and sign the last page indicating that he/she has completed the training packet
    - b) Host/Preceptor/Manager places signed form in student’s file.

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**Step 2 Continued:**

- **Document 5: Form D – HIPPA Security Quick Reference Guide** – This guide provides an outline of the HIPPA security policies. **Document found in Appendix D**  
**Directions:**
  - a) Host/Preceptor/Manager has student read guide and sign the last page indicating that he/she has completed the training
  - b) Host/Preceptor/Manager places signed form in student’s file.
  
- **Document 6: Form E – Background Information Sheet** – This information is being solicited for purposes of conducting criminal and/or other background checks. It takes an average of two weeks for background checks to clear. **Document found in Appendix E**  
**Directions:**
  - a) Host/Preceptor/Manager gives form to student to fill out and sign
  - b) Host/Preceptor/Manager returns completed form to Public Safety MC3925 to conduct background check (make sure that your name and mail code are on the form so that Public Safety can return)
  - c) Public Safety will return form to Host/Preceptor/Manager indicating whether the background check has been cleared
  - d) Host/Preceptor/Manager places cleared Background Information Sheet in student’s file

**Document 7: Form J – Certification of Non-Discrimination** – this form verifies that the Affiliating Agency regarding support of nondiscrimination against persons on account of their race, color, religious creed, age, marital or civil union status, national origin, ancestry, sex, mental retardation, physical disability or sexual orientation. **Document found in Appendix J**

**Directions:**

- b) Host/Preceptor/Manager sends form to the affiliating school/university along with the two contracts
- b) Affiliating school/university returns signed form to UCHC host/preceptor/manager along with the contracts
- c) Host/Preceptor/Manager places signed form in student’s file.

**Documentation for Students Under Age 18:** In addition to the first five documents above, the following documents listed below have to be completed as well.

- **Document 8: Form F – Parent Permission Form for Observational/Internship Student Experience** – This form is to be completed by the minor’s parent or legal guardian. It verifies that permission is granted for the student to participate in a Student Observational/Internship Experience at UCHC; and grants permission for the student to be treated medically and/or surgically in the event of an emergency while participating in the educational experience. **Document found in Appendix F**

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**Step 2 Continued:****Directions:**

- a) Host/Preceptor/Manager gives form to student to have parent/legal guardian fill out
  - b) Parent/legal guardian reads, fills out, and signs form
  - c) Student returns form to host/preceptor/manager
  - d) Host/Preceptor/Manager sends signed original form to the Office of Research Safety (MC3930)
  - e) Host/Preceptor/Manager retains a copy of form in student's file.
- **Document 9: Form G – Safety Clearance Form – for Minor Student's** – This form outlines the guidelines for safely supervising a student observer/intern who is a minor. **Document found in Appendix G**

**Directions:**

- a) Host/Preceptor/Manager completes form and returns to the Office of Research Safety, MC 3930, prior to student minor beginning their educational experience
  - b) Host/Preceptor/Manager reviews these guidelines with the student minor and others that may assist you with your duties as a preceptor
  - c) Host/Preceptor/Manager retains a copy of this form in the student's file.
- **Document 10: Form H: General Safety Information for Minors With Potential Exposure To Industrial Hazards/Safety Checklist for Student Minor With Potential Exposure To Industrial Hazards** – This form should be completed by host/ preceptor/ manager with the student minor when they first begin their educational experience. **Document found in Appendix H**

**Directions:**

- a) Host/Preceptor/Manager goes over 11 items on Safety Checklist Form with student minor
  - b) Both student minor and host/preceptor/manager initial each item in the appropriate column
  - c) Host/Preceptor/Manager returns completed form to the Office of Research Safety Office (MC3930)
  - d) Host/Preceptor/Manager retains a copy of this form in the student's file.
- **Document 11: Form I: Student Services Request/Position Description** – This two-paged form is to be completed by host/preceptor/manager for student minors in an area that has potential industrial exposure. **Document found in Appendix I**

**Directions:**

- a) Host/Preceptor/Manager fills out Parts I – IV of form
- b) Host/Preceptor/Manager returns completed form to the Office of Research Safety (MC3930)
- c) Host/Preceptor/Manager retains a copy of this form in the student's file.

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### **Step 3: Student File**

Host/Preceptor/Manager creates a student file for each student whether observational or an internship he/she is hosting. All student documents and forms should be housed in this file. Files should be kept on record by the host/preceptor/manager for **seven years** for legal purposes.

### **Step 4: Student Orientation/Safety Training**

- Once all documentation/forms are completed, host/preceptor/manager provides the student with the UCHC Orientation Self Learning Package (SLP)
- Student reads through the SLP and signs-off on form on last page of SLP
- Signed form is placed in student file
- Host/preceptor/manager contacts Department of Research Safety to arrange for appropriate safety training for student.

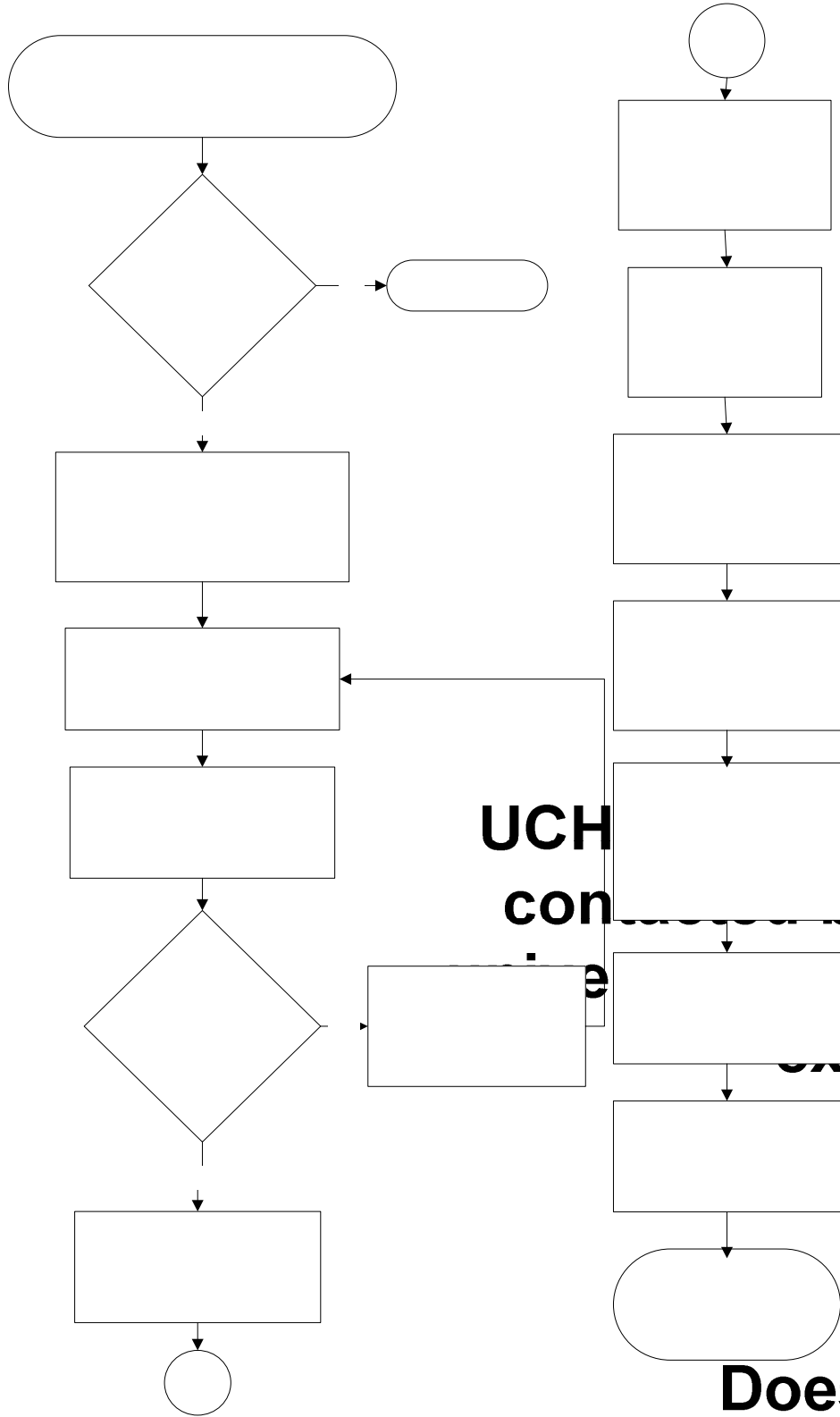
**Please note that students may not begin their UCHC educational experience without the required safety training.**

### **Step 5: UCHC Student Identification**

All students who are at the University of Connecticut Health Center participating in a school sponsored educational experience (observational or internship) must have appropriate UCHC identification obtained through the Department of Public Safety.

- Once all documentation/forms are completed, and student has signed off on the UCHC Orientation SLP, and attended the appropriate safety training class session, the host/preceptor/manager takes the student down to Public Safety to obtain UCHC identification to be worn while on the UCHC campus at all times

**If you have any questions, please contact the Department of Human Resources/Organization & Staff Development at (860) 679-3419.**



**Bringing**

**UCH preceptor/manager  
conducted by student school  
request educational  
experience**

**Does the Host/  
preceptor/manager  
agree to the**



# University of Connecticut Health Center

Form A

## VERIFICATION OF SCHOOL HELD STUDENT HEALTH RECORDS

2009 - 20010

I \_\_\_\_\_ verify that the administrative  
(School/Agency Contact)

offices of the of at \_\_\_\_\_ have on record for the  
(School of Origin)

student(s) listed on following page.

### **\*Health Requirements for Affiliation Experience**

- Evidence of 2 measles and mumps immunizations if born on or after January 1, 1957 (1 Vaccine must be documented after 1980) **and** documented immunity by positive laboratory titers for measles and mumps.
- Evidence of current immunization for rubella **and** an immune laboratory titer.
- Evidence of non-reactive PPD (not more than 6 months old) or documentation of treatment and resolution of active TB episode or documentation of a negative chest x-ray after a positive PPD.
- Documentation of current varicella (chickenpox) titer or verbal history of varicella **and** documentation of a positive immunity by laboratory titer.
- Documentation of declination or acceptance of Hepatitis B Immunization **and** a positive titer after 1<sup>st</sup> series. When the titer is negative, evidence of 2<sup>nd</sup> series of 3 doses **and** titer after that.

**Students Enrolled in a Student Observational/Internship Experience Program  
At the University of Connecticut Health Center**

Date of Experience: \_\_\_\_\_

**Please print clearly the following information on the space provided below:  
Student's Name, Address, and Local Phone Number.**

1.)
2.)
3.)
4.)
5.)
6.)
7.)
8.)
9.)
10.)

\_\_\_\_\_  
School Contact Authorized Signature                      Institution                      Date

This form is valid for students affiliating at the University of Connecticut Health Center.

Please return to the student's UCHC Host/Preceptor/Manager.

**Please Do Not send individual student health records to the University of Connecticut Health Center.**

**Completed Form MUST BE MAINTAINED in the student's file**

**POLICY NUMBER 2002-43**  
**Form B 04-05**

**POLICY: CONFIDENTIALITY**

**POLICY STATEMENT:**

This policy covers all persons working, volunteering or doing business with UCHC both during and after employment, volunteering and/or when business with UCHC has been completed or terminated. This policy prohibits confidential information as defined by Federal (such as Health Insurance Portability & Accountability Act), State of Connecticut (such as Freedom Of Information {FOI}) and UCHC policy (e.g. Research, JDH/UMG/Dental patient confidentiality) from being accessed, disclosed or released in any format to or by any person/business that does not have a "need to know" without the proper consent of the individual/patient involved and/or UCHC. In addition, certain information considered confidential by UCHC may be subject to State of Connecticut FOI but should not be released before obtaining specific authorizations from appropriate level of UCHC management. Formal FOI requests for confidential information should be sent to the Office of the Executive Vice President for Health Affairs.

• **Conduct of Personnel:** All individuals are expected to be professional and maintain confidentiality at all times, whether dealing with actual records, projects, or conversations, and abide by the obligations of contractual confidentiality agreements. Situations in violation of this policy include, but are not limited to:

- a. "Loose" talk among healthcare workers regarding medical information about any patient or fellow employee.
- b. Allowing unauthorized access on Health Center computers to confidential patient information, financial data, confidential research data, or employee personal information.
- c. Sharing of information acquired by persons in the course of their work to others who don't have a need to have the information; accessing information that the individual doesn't have the authority to access in the course of their work, or doesn't have a need to know to carry out their job duties.
- d. Disclosure of the anonymity or medical information of research participants without the research subject's permission.
- e. Sharing of information relative to confidential Human Resources matters.
- f. Breach of confidentiality obligations regarding the disclosure of confidential information that is subject to a duly signed confidentiality or research agreement.
- g. Discarding confidential documents in non-secured trash. (Secured shredder bins must be used).

**Examples of Types of Information to be Protected:**

**1. Patient Information:** Patient information must not be accessed, removed, discussed with or disclosed to unauthorized persons, either within or outside of the institution, without the proper consent of the patient. All individuals having access to confidential information are bound by strict ethical and legal restrictions on the release of medical data. No individual therefore may disclose to a third party, including his/her own family, information learned from medical records, patient accounts, management information systems, or any other confidential sources during the course of his/her work. No individual may access confidential information that they do not have a need to know to carry out their job duties. Employees may not access, release or discuss the medical information of other employees without proper consent, unless the employee must do so to carry out specific assigned job functions. Employee patient information should never be accessed for employment reasons. Employees

may not access their own medical, billing or scheduling information.

Confidentiality Policy  
Policy #2002-43 (5/20/04)  
Page 2

**2. UCHC Information:** UCHC information that must be protected includes but is not limited to:

- Ongoing negotiations (labor contracts, leases, purchases)
- Pending litigation and/or investigations
- Information that is proprietary, e.g., information that allows UCHC to be more competitive in the marketplace. For example: an innovative approach that is described in a grant proposal.

- Confidential commercial or financial information

This information may not be accessed, removed, altered or disclosed unless UCHC administration has given proper authorization.

**3. Individual Matters:** This includes personnel, medical, and other similar files where unauthorized access or release, falsification or destruction of confidential individual records is strictly prohibited.

- **Disposal of Confidential Documents:** Confidential documents must be disposed of utilizing the designated locked containers for shredding.

- **Reporting Breach of Confidentiality:** Persons must report violations of this policy. Options include reporting to a supervisor, Department Chairperson, UCHC Compliance Office, UCHC Privacy Officer, UCHC Information Security Officer or by calling the confidential “Reportline” at 1-888-685-2637.

- **Disciplinary Action for Non-compliance:** Violation of this policy is cause for disciplinary action up to and including dismissal.

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Peter Deckers, MD (signed) 6/24/04  
**Executive Vice President for Health Affairs Date**

- **Acknowledgement of Understanding:**

I acknowledge receipt and will comply with the UCHC Policy on Confidentiality. I understand that in the performance of my duties I must hold patient, personnel and organizational information in confidence. I recognize that I have a duty to report violations of this policy. I further understand that violations of this policy are cause for disciplinary action up to and including termination.

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<b>Signature</b>	<b>Name (Print)</b>	<b>Date</b>
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**Replaces:** Policy presented to Health Affairs Committee on September 1, 1994  
Senior Group Approval June 27, 1994  
Revised: 2/99, 10/00, 3/01, 8/02. 5/04



**Form C  
2009-2010**

Dear Student,

As many of you know, all health care organizations were required to be compliant with HIPAA Privacy Regulations as of April 2003. One of the requirements under the HIPAA Privacy Regulation is mandatory training for all students who, as part of their training, will be viewing protected health information. This training includes a review of the organization's policies and procedures relating to protecting patient information.

We have developed the attached training packet for your review and completion. It is a summary of your responsibilities as a student working at The University of Connecticut Health Center (UCHC). Completion of these materials will satisfy your training requirements for any UCHC site. At the end of the text is a self-scoring quiz of the materials.

Please sign the last page of the packet indicating that you have completed the training packet and return it to your instructor, host, and preceptor or individual that is responsible for your student rotation here at UHCC. Continued participation in your Program is contingent upon proof of completion of this material.

Thank you in advance for your cooperation,

Iris Mauriello, RN, CHC  
UCHC HIPAA Privacy Officer

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University of Connecticut Health Center (UCHC)  
Student HIPAA Privacy Training and  
Summary of Relevant HIPAA Privacy Policies  
**Academic Year 2009-2010**

The Health Insurance Portability and Accountability Act (HIPAA) was originally passed by Congress in 1996. In April of 2003 a key portion of this act, HIPAA Privacy Regulations, came into effect. All health care entities subject to these regulations must abide by these rules. HIPAA's privacy regulations **do not** supersede Connecticut State law where State requirements are more stringent. The Office of Civil Rights has been given the authority to enforce the privacy regulations. Both civil and criminal penalties are associated with violations of these regulations.

One of the administrative requirements of HIPAA Privacy regulations is training on the regulations as well as internal policies and procedures related to patient privacy. As a student at the University of Connecticut Health Center (UCHC), you are required to complete this self-learning packet and review the associated HIPAA privacy policies.

HIPAA privacy regulations require hospitals/clinics to have in place appropriate processes to safeguard Protected Health Information (PHI). These safeguards include:

- Access level security for information systems.
- Protocols for requesting patient information through the Department of Health Information Management.
- Protocols for confidential waste destruction.
- Speaking quietly while discussing a patient's condition with family members in public areas.
- Avoiding using the patient's name in publicly accessed areas.
- Not leaving protected health information unattended.
- Protecting personally assigned passwords and not sharing with others.
- Not sending protected health information over the Internet unless you confirm that it is encrypted.

In addition, all employees and medical staff members are reminded not to conduct conversations about patients in public areas such as public elevators, corridors, lobbies and the cafeteria. Although the regulations acknowledge that there will occasionally be an incidental disclosure, such occurrences should be unavoidable and limited in nature.

HIPAA also imposes changes to the approval process for research. All research conducted at UCHC must be reviewed and approved/waived by the Institutional Review Board (IRB).

All HIPAA Privacy Policies and Procedures can be located via the UCHC Home Page at [www.uchc.edu](http://www.uchc.edu). Click on “Faculty and Staff”, look for the section entitled “Reference”, click on “UConn Health Center Policies”, and click on “HIPAA Privacy Policies.”

Completion of this training material will satisfy your training requirement for:

- University of Connecticut Health Center
- John Dempsey Hospital
- University Medical Group
- University of Connecticut Health Partners

### **Protected Health Information (PHI)**

PHI is defined as any individually identifiable health information that is maintained or transmitted in any form. There are many “identifiers” that can link an individual to health information (i.e. name, address, SS#, insurance plan numbers, email address etc.). ***All health information that can be linked to an individual must be protected.***

Refer to UCHC policy # 2003-03 “Privacy Definitions” for more detailed explanations of PHI and other HIPAA related terms.

### **Notice of Privacy Practices**

Under the HIPAA regulations patients are entitled to receive a “Notice of Privacy Practices” which informs patients about how their PHI is used and disclosed as well as their rights and how to exercise those rights. This notice is completed and acknowledged by the patient at the time of first service delivery as part of the “Permission to Treat” form (HCH 901). Returning outpatients will be asked to sign the form every six months thereafter and inpatients will be asked to sign the form at the time of each admission.

The UCHC “Notice of Privacy Practices” may be found at <http://health.uchc.edu/privacy/index.htm>.

Refer to UCHC policy # 2003-13 “Permission to Treat/Assignment of Benefits/Authorization to Release Medical/Dental Records/Acknowledgement of Receipt of Notice of Privacy Practices” and the associated form for more information.

### **Sharing PHI Without Authorization**

Healthcare providers may share PHI *without* patient authorization for:

- Treatment within and between UCHC providers (i.e. JDH, UMG, UCHP).
- Payment for treatment.
- Health care operations (i.e. quality improvement, training, compliance reviews, evaluating caregiver performance).

There are other specific circumstances where authorization is not required before disclosing PHI.

Refer to UCHC policy #2003-27 “*Use and Disclosure of PHI Where Authorization or Opportunity for Patient to Agree or Object is **NOT** Required*” and “*Certification Regarding Subpoena*” for more information.

### **When is authorization required for disclosure of PHI?**

In general, if access, use, or disclosure of PHI does not fall within the treatment, payment, or operations categories outlined above you must have the patient’s signed authorization. A valid authorization includes specific requirements. Always use UCHC HIPAA compliant authorization forms. A patient may withdraw authorization at any time except to the extent that UCHC has already used or released information while the authorization was still valid. Written revocation must be made to the Director of Medical Records.

Refer to UCHC policy # 2003-16 “*Authorization for Release of Information*” and associated authorization form for more information.

### **Disclosure of PHI to Friends and Family Members Involved in a Patient’s Care**

When the patient is present and has the capacity to make health care decisions, UCHC will provide the patient an opportunity to agree or object to the disclosure of protected health information to friends or family members involved in his/her care before the disclosure occurs.

When the patient is not present, or the opportunity to agree or object to the disclosure cannot practicably be provided because of the patient’s incapacity or an emergency circumstance, UCHC may determine whether the disclosure is in the best interests of the patient.

Refer to UCHC policy #2003-25 “*Use and Disclosure Involving Family and Friends*” for more detailed information.

### **Disclosure of Patient Information to the Public and Community Clergy Members**

Unless a patient objects, UCHC may disclose that patient’s location (room number and telephone number) to persons who inquire about that patient **by name**. Members of the clergy will also be provided a patient’s religious affiliation unless the patient objects.

Inquiries made by the media/press must be directed to the UCHC Office of Communications. The telephone operator will assist.

Refer to UCHC policy #2003-26 “*Directory Information: Disclosure of a Patient’s Information*” for more detailed information.

**Disclosure of PHI via E-mail**

PHI should be hand delivered or mailed whenever possible. However, e-mailing of patient information internally to authorized personnel **within the UCHC system** is allowable to facilitate treatment, payment and health care operations. These e-mails can **only** be sent from and to secure e-mail addresses within the UCHC network. UCHC defines a secure e-mail address as one that ends either with *uchc.edu* or *uchp.org*.

**E-mails of PHI cannot be sent unless the recipient address can be verified as being secure.**

Refer to UCHC policy #2003-22 “*E-Mail: Use and Disclosure of Protected Health Information*” and “*HIPAA Email Policy Attachment*” for more detailed information.

**Disclosure of PHI via Facsimile**

Faxing of patient information outside of the facility is allowable in situations when health information is needed immediately for patient care purposes, continuing care placement, payment or when mail or courier delivery will not meet a necessary timeframe.

Employees authorized to FAX patient health information must confirm the accuracy of the FAX numbers and security of recipient machines by calling the intended recipients to verify the numbers and notify them that the FAX is on the way.

When expecting the arrival of a FAX containing PHI schedule with the sender whenever possible to ensure that the faxed documents can be promptly removed from the FAX machine.

Facsimile machines that receive and/or transmit health information must be located in a secure and controlled area so information being displayed or printed is not accessible to unauthorized users.

Refer to UCHC policy # 2003-23 “*Faxing of Protected Health Information*” and fax cover sheet for more detailed information.

**Disclosure of Protected Health Information by Whistleblowers**

PHI may be used or disclosed by whistleblowers or workforce member or student crime victims under certain circumstances. If the workforce member believes in good faith that UCHC has engaged in conduct that is unlawful or otherwise violates professional or clinical standards, the workforce member may disclose PHI to the UCHC Corporate Compliance Office and/or a government agency. A member of the UCHC workforce or student who is the victim of a crime may disclose PHI to a law enforcement official, provided that the PHI disclosed is about the suspected perpetrator of the crime and the PHI disclosed is limited to certain data items.

Refer to UCHC policy # 2003-08 “*Use and Disclosure of Protected Health Information by Whistleblowers and Workforce Member Crime Victims*” for more detailed information.

**Restrictions on the Use and Disclosure of PHI**

Patient care units and departments must review and honor approved patient requests for restrictions before using or disclosing protected health information. All restriction agreements must be documented.

Refer to UCHC policy #2003-14 “*Patient Right to Request Restrictions on Use and Disclosure of Protected Health Information*” for more detailed information.

**Patient Request for Confidential Communication**

Patient care units and departments must review and, if operationally feasible, honor all patient requests for confidential communications before using or disclosing protected health information. UCHC will approve requests for one alternative mailing address and/or telephone number at the time of the request.

Refer to UCHC policy #2003-15 “*Patient Right to Request Confidential Communications*” for more detailed information.

**Minimum Necessary Data**

Minimum necessary data means limiting the request for use or disclosure of PHI to the minimum necessary to accomplish the intended purpose. The concept of minimum necessary does not apply to treatment situations with patients and a few other uses and disclosures required by law.

UCHC will make reasonable efforts to limit the request for use or disclosure of PHI to the minimum necessary to fulfill assigned duties. Health care providers are reminded to consider the concept of minimum necessary data in all activities where use, disclosure and requests for PHI are made.

Refer to UCHC policy # 2003-21 “*Minimum Necessary Data*” for more information.

### **Verification of Requests Related to PHI**

UCHC will verify the identity of any person requesting access to or disclosure of protected health information, if the staff member responding to the request does *not* know such person. Once any requester's identity is verified, staff may use whatever means are available to them in their department to determine the person's authority to have the information requested. Staff may only disclose minimum necessary information unless the request is solely for the patient's treatment.

In the event that the identity and/or legal authority of an individual or entity cannot be verified, UCHC staff will *not* make the requested disclosure of PHI, and will report the request for PHI to their immediate supervisor.

Refer to UCHC policy # 2003-20 "*Verification of Individuals or Entities Requesting Disclosure of Protected Health Information*" for more information and specific procedures for verifying requester.

### **Use of Portable Computing Devices (PCD)**

Whenever PHI is kept on a PCD, it must be in encrypted format and have secure password protection approved by UCHC. The information should only be maintained on these devices as long as it is absolutely necessary, then it should be deleted. At the end of your association with the hospital/clinic you *must* delete all patient information from your personal devices.

Refer to UCHC policy # 2003-32 "*Portable Computing Device (PCD) Security Policy*" for specific procedures.

### **Disposal of Confidential Information**

Any printed material (e.g., faxes, printed emails, informal notes about patients) containing PHI must *not* be discarded in trash bins, unsecured recycle bins or other publicly accessible locations. Instead this information must be personally shredded or placed in secured shredder bins. If you have in your possession copies of protected health information in preparation for case presentations or other academic requirements, you are obligated to destroy this material in a confidential manner.

Secure methods will be used to dispose of electronic data and output. The Materials Management Department is responsible for the removal of all UCHC information, including PHI, residing on any electronic storage media/device prior to removal or sale of such devices.

See UCHC policy # 2008-01 "*Disposal of Documents/Materials Containing PHI and Receipt, Tracking, and Disposal of Equipment and Electronic Media Containing Electronic Protected Health Information*" for specific procedures.

### **Patient Requests to Review, Copy, or Amend their PHI**

Patients have the right to request to review, copy or amend the health information contained in their medical/dental records or billing records. All requests must be made in writing and will be reviewed with the patient's attending of record. UCHC and the physician will determine if the request will be honored and will provide a written response to the patient for any denial of the request. The original medical/dental/billing record is the property of UCHC and may *not* be removed from the facility except by court order.

Refer to UCHC policy #2003-17 "*Patient Right to Inspect, Copy, and Amend their Medical Record*" and associated forms for more information.

### **Patient Requests for Accounting of PHI Disclosures**

With the exception of disclosures for treatment, payment or health care operations patients have the right to request in writing an accounting of all disclosures of their PHI of which they would not otherwise be aware (i.e. regulatory agencies, in response to subpoenas). All such disclosures are recorded on an accounting log. For disclosures that may be made many times for the same purpose to the same person or entity, some of the accounting may be summarized.

Refer to UCHC policy # 2003-18 "*Accounting of Disclosures of Protected Health Information to Patients Upon Their Request*" and associated forms for more detailed information.

#### **Remember:**

**If you suspect any breaches of privacy or non-compliance with HIPAA Privacy regulations you may report your concerns to:**

- **your immediate supervisor or major advisor.**
- **the UCHC Corporate Compliance Integrity and Privacy Officer, Iris Mauriello. Phone number 860-679-3501 E-mail: [mauriello@nso1.uchc.edu](mailto:mauriello@nso1.uchc.edu)**
- **the confidential REPORTLINE for the University of Connecticut Health Center: Phone number 1-888-685-2637.**
- **the Office of Civil Rights.**

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Self Quiz

**True or False: A Notice of Privacy Practices will be given to patients when they are first seen in a clinic or admitted to the Hospital explaining how the hospital will use and disclose their protected health information.**

*True or False: A patient authorization is required to release protected health information to an attorney. (Note: assume a subpoena has not been issued for the information.)*

*True or False: A patient has no choice but to be included in the facility directory.*

*True or False: A patient may request an amendment to his/her protected health information.*

*True or False: It's OK to discuss patients in the public elevator with colleagues regardless of who's in the elevator.*

*True or False: It is fine to conduct research without IRB approval.*

**True or False: I should report any known breaches of the HIPAA Privacy requirements at UCHC to my immediate supervisor, the UCHC HIPAA Privacy Officer, or UCHC REPORTLINE.**

Answers: T, T, F, T, F, F, T



Please read and then print and sign your name below. Send the signed form to:

**PLEASE ENTER PERSON NAME HERE WHO CAN TRACK RETURNS FOR YOUR DEPT.**

**Certification of HIPAA Privacy  
Training Packet Completion  
Academic Year 2009-2010**

I have read and understand the University of Connecticut Health Center HIPAA Privacy training materials. Further, I understand that the location of additional information about UCHC's policies and procedures related to patient privacy have been detailed in the training documents.

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Printed Name

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Signature

Date



# University of Connecticut Health Center

**FORM D**  
**University of Connecticut Health Center**  
**HIPAA SECURITY**  
**QUICK REFERENCE GUIDE**  
**2009 - 2010**

## **What is HIPAA?**

The Health Insurance Portability and Accountability Act is a federal law. HIPAA provides for:

- Enhanced privacy to protect individually identifiable health information (protected health information or PHI) in any form (oral, paper, electronic) and enhanced patients rights with respect to their PHI (effective April 14, 2003);
- Standard security measures to ensure confidentiality, integrity, and availability of data (effective April 20, 2005).

## **What is considered Protected Health Information (PHI) and Electronic Protected Health Information (ePHI)?**

PHI Information is believed to identify an individual if it includes either the individual's name or any other information that could enable someone to determine the individual's identity.

Protected Health Information may include:

- Name and address
- Geographic identifiers such as address and zip code
- Telephone or fax numbers
- Health care specifics
- Social Security or medical records numbers

Examples of **ePHI** include any medium used to store, transmit, or receive PHI electronically, such as the following:

- Personal Computers with their internal hard drives used at work, home, or traveling
- External portable hard drives, including iPods
- Magnetic tape or disks
- Removable storage devices such as USB memory sticks/ keys, CDs, DVDs, and floppy diskettes
- PDA's, smart phones
- Electronic transmission includes data exchanges via wireless, Ethernet, modem, DSL or cable network connections.

**Who does HIPAA Security apply to?**

HIPAA Security standards apply to covered entities, such as the Health Center. A covered entity is a health plan, a health care clearinghouse, or a health care provider who transmits any health information in electronic form in connection with a transaction covered by HIPAA. HIPAA Security standards apply to all individuals who have equipment connected to the UCHC network. In addition, it applies to all individuals at UCHC, because as a member of the UCONN Health Center community you may come in contact with patient information.

**What are HIPAA Security Standards?**

HIPAA Security Standards are Federal rules that:

- Define administrative, physical, and technical safeguards to protect electronic protected health information.
- Require implementation and documentation of basic safeguards.
- Protect PHI currently or previously in electronic form.

**How do I comply with the Security Standards?** As a member of this community you must do the following:

- Always wear your Health Center Identification provided to you from the Department of Public Safety.
- Adhere to UCHC guidelines for creating appropriate passwords- see Policy Number 2005-05; if there are questions, see your systems administrator
- Memorize your passwords and log off your computer by using password-protected screen savers when you are not at your work station
- Do not use e-mail to send or transmit ePHI to internal or external recipients.
- If you receive an e-mail attachment from someone you don't know, don't open the attachment. And don't forward it to anyone. Instead, delete it and report it to your supervisor and the Help Desk.
- Unless authorized, never install any software on your computer.
- If you suspect that your computer may be infected with a virus, immediately report it to your supervisor and the Help Desk.
- Never load data files from outside CDs and diskettes without first scanning them for viruses.
- Back-up all data files containing ePHI and other sensitive information and encrypt and/or password-protect
- If using a mobile device, protect against unauthorized access by utilizing passwords and encryption
- Keep all file cabinets and rooms that contain PHI locked.

**How do I comply with the Security Standards?** As a member of this community you must do the following:

- Always wear your Health Center Identification provided to you from the Department of Public Safety.
- Adhere to UCHC guidelines for creating appropriate passwords- see Policy Number 2005-05; if there are questions, see your systems administrator
- Memorize your passwords and log off your computer by using password-protected screen savers when you are not at your work station

- Do not use e-mail to send or transmit ePHI to internal or external recipients.
- If you receive an e-mail attachment from someone you don't know, don't open the attachment. And don't forward it to anyone. Instead, delete it and report it to your supervisor and the Help Desk.
- Unless authorized, never install any software on your computer.
- If you suspect that your computer may be infected with a virus, immediately report it to your supervisor and the Help Desk.
- Never load data files from outside CDs and diskettes without first scanning them for viruses.
- Back-up all data files containing ePHI and other sensitive information and encrypt and/or password-protect
- If using a mobile device, protect against unauthorized access by utilizing passwords and encryption
- Keep all file cabinets and rooms that contain PHI locked.

**HIPAA Security Standards:**

<b>HIPAA Security Standard</b>	<b>*See Our Policy and Procedure</b>
<p><b>Administrative Safeguards:</b></p> <ul style="list-style-type: none"> <li>• Assign security responsibility within the organization.</li> <li>• Develop policies and procedures to address security violations. This includes completing a risk analysis, implementing security measures to reduce risks and vulnerabilities, developing a sanction policy, and implementing procedures to review records of system activity on a regular basis.</li> <li>• Attend to workforce security including: workforce clearance procedures, termination procedures and authorization, and/or supervision of workforce and management.</li> <li>• Establish policies and procedures for granting access to ePHI.</li> <li>• Provide security awareness training to the workforce and management.</li> <li>• Identify and respond to security incidents.</li> <li>• Implementing policies and procedures for responding to an emergency: including plans to back up data, recover after a disaster, and operate during a disaster or emergency.</li> <li>• Periodically evaluate the organization's compliance with the Security standards.</li> </ul>	<p>Policy Number 2005-02: UCHC HIPAA Security Acceptable Use</p> <p>Policy Number 2005-03: UCHC HIPAA Security Administration</p> <p>Policy Number 2005-05: UCHC HIPAA Security Information Systems Access Control</p> <p>Policy Number 2003-09: Breaches of Privacy &amp; Security of Protected Health Information (PHI): Reporting Requirements, Sanctions, and Mitigation</p> <p>Policy Number 2005-06: UCHC HIPAA Security Information Systems and Business Continuity and Disaster Recovery</p> <p>Policy Number 2003-07: UCHC Training of Workforce: HIPAA Privacy &amp; Security</p>
<p><b>Physical Safeguards:</b></p> <ul style="list-style-type: none"> <li>• Limited physical access to electronic information systems and the facilities in which they are housed.</li> <li>• Proper authorization for access.</li> <li>• Standards that ensure proper workstation use and physical security of workstations that access ePHI.</li> <li>• Standards for device and media controls.</li> </ul>	<p>Policy Number 2005-01: UCHC HIPAA IT Security: Data Authentication, Physical Safeguards</p> <p>Policy Number 2005-04: UCHC HIPAA Security Facility Access Control</p> <p>Policy Number 2005-10: UCHC HIPAA Security Virus Protection Policy</p> <p>Policy Number 2005-09: UCHC HIPAA Security Tracking and Disposal of Equipment and Electronic Media Containing ePHI</p>

<p><b>Technical Safeguards:</b></p> <ul style="list-style-type: none"> <li>• Technical policies and procedures for access control on systems that maintain ePHI. These systems must allow for unique user identification and include an emergency access procedure for obtaining necessary ePHI during an emergency. Addressable specifications include automatic logoff and encryption and decryption.</li> <li>• Hardware, software, and/or procedural methods for providing audit controls.</li> <li>• Mechanisms to validate the ePHI has not been altered or destroyed in an unauthorized manner.</li> </ul>	<p>Policy Number 2005-01: UCHC HIPAA IT Security: Data Authentication, Physical Safeguards</p> <p>Policy Number 2005-07: UCHC HIPAA Security Information System Activity Review</p> <p>Policy Number 2005-08: UCHC HIPAA Security Risk Management, Evaluation and Audit</p>
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**POLICY NUMBER 2008-03**

**May 27, 2008**

**POLICY: MOBILE COMPUTING DEVICE (MCD) SECURITY**

**PURPOSE:**

The University of Connecticut Health Center (UCHC) has established this policy for the secure implementation and deployment of mobile computing and storage devices within UCHC to support both privacy and security of sensitive information and compliance with applicable agency and regulatory requirements (e.g. HIPAA, NIH, HHS.)

**SCOPE:**

This policy applies to:

- Employees (including faculty and staff)
- Volunteers
- Residents
- Temporary staff
- Agency and contracted staff
- Credentialed staff
- Members of the Board of Directors

This policy covers portable or mobile computing and telecommunications devices (referred to as MCD's) that can execute programs or store data. Because all MCD equipment used at the Health Center is institutional property, regardless of funding source, this definition includes all UCHC laptop computers, PDAs, BlackBerry® devices, and USB storage devices.

**DEFINITIONS:**

**Confidential or restricted data**

Includes, but is not limited to, personally-identifiable information that is not in the public domain and if improperly disclosed could be used to steal an individual's identity, violate the individual's right to privacy or otherwise harm the individual. Organizational information that is not in the public domain and if improperly disclosed might: cause a significant or severe degradation in mission capability; result in significant or major damage to organizational assets; result in significant or major financial

loss; or result in significant, severe or catastrophic harm to individuals. This data may include, but is not limited to: Mobile Computing Device Policy # 2008-03 (5/27/08)

- Student information
- Medical/Dental/Behavioral Health-related patient information (ePHI)
- Other sensitive Health Center information not in the public domain
- Financial information about the Health Center (budgets, strategic revenue plans, accounts receivable/payable details)
- Employee HR and financial information
- Any information about employees, students, patients, Board Members, etc. which includes Social Security numbers
- IDs and/or Passwords for access to Health Center computing resources
- Research data requiring protections (clinical trials, patient survey responses, etc.) as required by the NIH

## **POLICY STATEMENTS:**

### **Permissible Use**

UCHC confidential or restricted data is not authorized to be stored on a UCHC or non-UCHC MCD unless the criteria below are met:

1. The device stores only the minimum data necessary to perform the function necessitating storage on the device
2. Information is stored only for the time needed to perform the function
3. The device is encrypted using methods authorized by the UCHC IT Department
4. Data is protected from any and all forms of unauthorized access and disclosure

### **IT Responsibilities**

1. The UCHC IT Department will provide Mobile Computing Device users with approved and properly updated software-based security mechanisms which may include anti-virus, anti-spyware, device locating, encryption, firewalls, and intrusion detection.
2. The UCHC IT Department will work with the Security Breach Team to establish, document, and maintain reporting, mitigation and remediation procedures for lost or stolen mobile devices containing UCHC data and for UCHC data that is compromised through accidental or non-authorized access or disclosure.

### **Mobile Computer Device User Responsibilities**

1. Users may not bypass or disable security mechanisms under any circumstances.
2. Users in the possession of UCHC-owned mobile devices during transport or use in public places, meeting rooms and other unprotected areas must not leave these devices unattended at any time, and must take all reasonable and appropriate precautions to protect and control these devices from unauthorized physical access, tampering, loss or theft.

3. Unauthorized physical access, tampering, loss or theft of the device must immediately be reported to the UCHC IT Help Desk in order to initiate effective and timely response and remediation.
4. Basic Science users who do not store confidential or restricted data may optionally use the device encryption software provided and supported by the UCHC IT Department.

## **Governance**

1. Failure to adhere to this security policy and associated procedures may result in sanctions as per applicable UCHC policy.

Sandra Armstrong (signed) June 16, 2008

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## **Chief Information Officer Date**

Peter Deckers, M.D. (signed) June 18, 2008

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**Executive Vice President for Health Affairs Date**  
**Replaces Policy #2003-32 Originally issued 4/14/03**  
**Updated: May 27, 2007**

\*The complete UCHC HIPAA Privacy Policies are available online at:

[http://www.policies.uchc.edu/area/HIPAA\\_Privacy.html](http://www.policies.uchc.edu/area/HIPAA_Privacy.html).

\*The complete UCHC HIPAA Security Policies are available online at:

[http://www.policies.uchc.edu/area/HIPAA\\_Security.html](http://www.policies.uchc.edu/area/HIPAA_Security.html).

## **Who enforces the Security standards?**

The center for Medicare and Medicaid Services within the U.S. Department of Health and Human Services will enforce the security standards.

## **Civil and Criminal Penalties**

Congress provided civil and criminal penalties for covered entities that misuse personal health information. For civil violations of standards, Office for Civil Rights may impose monetary penalties up to \$100 per violation, up to \$25,000 per year, for each requirement or prohibition violated. Criminal penalties apply for certain offenses; up to \$100,000 and up to five years in prison if the offenses are committed under "false pretenses"; and up to \$250,000 and up to 10 years in prison if the offenses are committed with the intent to sell, transfer or use protected health information for commercial advantage, personal gain or malicious harm.

## **Who to Contact**

If you believe privacy rights have been violated or that security breaches have occurred, these must be reported. UCHC Policy Number 2003-09 gives some examples of breaches of confidentiality and security (also known as **security incidents**). Other occurrences that may constitute a security incident are:

- a stranger using your computer
- odd behavior or degraded performance from your computer
- seeing information on your computer that you do not regularly have privilege to see
- data that suddenly changes for unknown reason
- missing files or unusual files appearing on your drive (server or hard drive)

- changes in access privileges
  - suspected password compromise (activity showing up under your user id that you know you did not do)
  - last network logon from your computer was not your user id
- 
- For suspected PRIVACY rights violations, you must contact:  
**Iris Mauriello, RN, Corporate Compliance Integrity and Privacy Officer, at 860-679-3501 or [mauriello@nso1.uchc.edu](mailto:mauriello@nso1.uchc.edu).**
  - For suspected SECURITY breaches you must contact:  
**The IT Help Desk at x.4400 or Jonathan Carroll, UCHC Information Security Officer, at 860-679-3528 or [jcarroll@uchc.edu](mailto:jcarroll@uchc.edu).**

FORM D

*University of Connecticut Health Center  
HIPAA SECURITY  
QUICK REFERENCE GUIDE*

**Certificate of HIPAA Security Awareness  
Training Completion**

I have read and understand the University of Connecticut Health Center’s HIPAA Security Quick Reference Guide. Further, I understand that the full HIPAA Security Policies can be obtained from my department manager or found online at:  
[http://www.policies.uhc.edu/area/HIPAA\\_Security.html](http://www.policies.uhc.edu/area/HIPAA_Security.html).

Your signature indicates that you have received, read, understood, and will abide by all the above information concerning HIPAA Security Standards.

Please return this form to either:

- your preceptor (if you are a student) for placement in your student file.
- HR (MC 1051) if you are an employee

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<b>Signature</b>	<b>Date Signed</b>
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<b>Print Name</b>	<b>Department</b>
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<b>Supervisor Signature</b>	<b>Date Signed</b>
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<b>Print Name</b>	<b>Department</b>
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FORM E Background Information Sheet



BACKGROUND INFORMATION SHEET

PLEASE COMPLETE ALL SECTIONS AND SIGN AT THE BOTTOM

The following information is being solicited for purposes of conducting pre-employment criminal and/or other background checks only and is not used in employment decisions unrelated to the results of the background check.

Name: \_\_\_\_\_  
Last First Middle (spell out)

Social Security Number: \_\_\_\_\_

Marital Status:  Single  Married  Divorced

Maiden Name: \_\_\_\_\_

Aliases: \_\_\_\_\_

\_\_\_\_\_ Race \_\_\_\_\_ Eyes \_\_\_\_\_ Height  
 \_\_\_\_\_ Sex \_\_\_\_\_ Hair \_\_\_\_\_ Weight

Physically Disabled:  Yes  No

Identifying Scars/marks/tattoos (type & location): \_\_\_\_\_

Home Address: \_\_\_\_\_  
Number Street City/Town State Zip

Date of Birth: \_\_\_\_\_  
MM/DD/YYYY

Place of Birth: \_\_\_\_\_  
City and State or Country

Citizenship: \_\_\_\_\_ Visa Status: \_\_\_\_\_

Drivers License  Yes  No State \_\_\_\_\_ # \_\_\_\_\_

List the states that you have lived in the last 5 years: \_\_\_\_\_

► Are you related to, or an unmarried partner of, an employee at the UConn Health Center?  YES  NO If "YES" list below. Continue on the reverse side if necessary. Per UCHC Policy #2002-51 a relative is a spouse, father, mother, sister, brother, child, the spouse of a child, or any relative who is domiciled in the employee's household

NAME	RELATIONSHIP	DEPARTMENT

► Have you ever been CONVICTED of an offense against criminal or military law, or are there criminal charges currently pending against you? (Exclude minor traffic violations, or any offense settled in juvenile court or under a youth offender law)  YES  NO  
 If "YES" list all cases below, providing details as indicated. Continue on the reverse side if necessary.

Special Note: You are not required to disclose the existence of any arrest, criminal charge or conviction, the records of which have been erased pursuant to Connecticut General Statutes § 46b-146, 54-76o, or 54-142a. If your criminal records have been erased pursuant to one of these statutes, you may swear under oath that you have never been arrested. Criminal records that may be erased are records pertaining to a finding of delinquency or that a child was a member of a family with service needs (C.G.S. § 46b-146), an adjudication as a youthful offender (C.G.S. § 54-76o), a criminal charge that has been dismissed or nolleed, a criminal charge for which the person has been found not guilty or a conviction for which the person received an absolute pardon (C.G.S. § 54-142a).

DATE	PLACE	COURT LOCATION	OFFENSE(S)	DISPOSITION

► Have you ever been excluded, disbarred, restricted, disqualified, or sanctioned from any Federal or State programs or government organizations?  YES  NO If "YES" list all cases below, providing details as indicated. Continue on the reverse side if necessary.

DATE	PLACE	AGENCY	FUNDING	CURRENT STATUS

For the CMHC program, fingerprints taken by the Department of Correction will be submitted to the Connecticut State Police and the FBI for a criminal history

► Have there ever been any actions against your professional license(s)?  YES  NO  N/A  
 If "YES" list all cases below, providing details as indicated. Continue on the reverse side if necessary.

DATE	PLACE	AGENCY	FUNDING	CURRENT STATUS

► Have you brought or will you be bringing (or having transported) to the UCHC ANY biological materials that are pathogenic in humans, animals or plants, including but not limited to viable organisms or genetic elements of pathogenic viruses, bacteria, biological toxins, fungi, rickettsia, mycoplasma or parasitic organisms?  YES  NO

If "YES", IMPORTANT NOTE: You must contact Research Safety 860/679-2723 or rwallace@adp.uhc.edu before transporting any biological, chemical or radioactive materials to the UCHC.

I \_\_\_\_\_ certify that the information provided by me on the Background Information Sheet is COMPLETE and TRUE to the best of my knowledge and is made in good faith. I understand that if I knowingly make any misstatement of facts or fail to provide required information I am subject to disqualification or dismissal and other penalties as they may be prescribed by law, policy, or regulation.

SIGNATURE: \_\_\_\_\_ DATE SIGNED: \_\_\_\_\_

<p><b>OFFICIAL USE ONLY</b></p> <p>This area must be completed by the Human Resources Officer or the Hiring Department</p>	Submitted by:	<input type="checkbox"/> L Barrows <input type="checkbox"/> B Camilleri <input type="checkbox"/> J Duggal <input type="checkbox"/> M Leone <input type="checkbox"/> N Logan <input type="checkbox"/> L Stockwell <input type="checkbox"/> D Gillon <input type="checkbox"/> J Mastriani <input type="checkbox"/> P Verdi <input type="checkbox"/> Other: _____	<p><b>PUBLIC SAFETY USE ONLY</b></p> <input type="checkbox"/> Cleared <input type="checkbox"/> Rejection based on failure to disclose <input type="checkbox"/> Administrative Review Pending <input type="checkbox"/> Administrative Review Complete Date/Outcome: _____  <input type="checkbox"/> Unable to process due to missing: _____
	Return to:	<input type="checkbox"/> L Barrows <input type="checkbox"/> B Camilleri <input type="checkbox"/> J Duggal <input type="checkbox"/> M Leone <input type="checkbox"/> N Logan <input type="checkbox"/> L Stockwell <input type="checkbox"/> A. Smith <input type="checkbox"/> Other: _____	
	Area:	<input type="checkbox"/> Clinical Operations <input type="checkbox"/> Dental Clinics <input type="checkbox"/> Research <input type="checkbox"/> Day Care <input type="checkbox"/> Non-Clinical <input type="checkbox"/> Clinical Faculty <input type="checkbox"/> IT <input type="checkbox"/> CMHC	
	Employee Type:	<input type="checkbox"/> Paid <input type="checkbox"/> Volunteer <input type="checkbox"/> Grad Assistant <input type="checkbox"/> Dental Resident/Non-Surgical <input type="checkbox"/> Non-Paid <input type="checkbox"/> Student <input type="checkbox"/> Contractor: _____	
	Job Title:	_____	
Position Requirements:	Does Position require IDX Use? <input type="checkbox"/> Yes <input type="checkbox"/> No Does Position Require LCR (Lifetime Clinical Record)? <input type="checkbox"/> Yes <input type="checkbox"/> No Grant Funded? <input type="checkbox"/> Yes <input type="checkbox"/> No	Ref: 05/19/05	



# University of Connecticut Health Center

## Form F

### Parent Permission Form for A Non Paid Observational/Internship School Sponsored Student Educational Experience 2009-2010

**To Be Completed By A Parent Or Legal Guardian (If student is 15 or older, but less than 18 years of age)**

In accordance with the University of Connecticut Health Center's policy statement Minors in the Workplace, we must obtain a written informed parental consent from a parent or legal guardian of a minor student who is under 18 years of age and wants to have a student observational/affiliation experience at the University of Connecticut Health Center (UCHC).

I grant permission for my son/daughter **(Print Full Name)** \_\_\_\_\_ to participate in a Student Observational/Internship Experience. To the best of my knowledge, he/she is in good health and is able to participate in this endeavor with the following physical limitations:

\_\_\_\_\_.

I understand that there are potential risks, including but not limited to exposure to lab activities, human materials and radioactive materials.

I also understand that the following controls will be taken to minimize risks: Safety Training, Supervision by Host/Preceptor/Manager, Use of Appropriate Protective Equipment

In consideration for (name of son/daughter) \_\_\_\_\_'s participation in the above-stated Student Observational/Internship Experience, I hereby release, waive, discharge, and covenant not to sue the State of Connecticut, the University of Connecticut, the University of Connecticut Health Center, and its/ their officers, employees, and agents for liability from any and all claims including the negligence, of its officers, employees and agents, resulting in personal injury, accidents or illnesses (including death), and property loss arising from, but not limited to, my son/daughter's participation in said program.

I agree to HOLD HARMLESS the State of Connecticut, the University of Connecticut, the University of Connecticut Health Center and its/ their officers, employees, and agents from any and all claims, actions, suits, procedures, costs, expenses, damages and liabilities, including attorney's fees brought as a result of \_\_\_\_\_'s participation in the above-stated Student Observational/Internship Experience. Son/daughter

I understand that the University of Connecticut Health Center conducts background checks on all individuals, regardless of age, participating in non-paid educational experiences on site. I grant my permission to have this background check done on my son/daughter.

Additionally, the University of Connecticut Health Center is given permission to reproduce for publications any photos taken of my child during his/her participation in the Student Observational/Affiliation Experience, and said photos shall be the property of the University of Connecticut Health Center.

\_\_\_\_\_  
**Signature of Parent or Legal Guardian** **Date**

Name of parent or legal guardian: \_\_\_\_\_  
 Home Telephone Number: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

Work Telephone Number: (Mother) \_\_\_\_\_ (Father) \_\_\_\_\_

Family Physician: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Person to notify in case of emergency: \_\_\_\_\_

Telephone/Cell Phone Number: \_\_\_\_\_ Relationship: \_\_\_\_\_

The University of Connecticut Health Center requires that all minors (those 15 or older but less than 18 years of age) must have on file "Consent for Treatment" form, signed by a parent or legal guardian before the applicant can be accepted in an Observational/Affiliation Experience Program and begin his/her assignment at John Dempsey Hospital/ University of Connecticut Health Center.

This is a preventive measure in case of illness or injury of a minor while participating in the program, and would be used only if reasonable attempts to reach the parent or guardian have been made.

**CONSENT FOR TREATMENT**

In the event \_\_\_\_\_ required medical and/or surgical  
*(Name of Observational/Intern Participant)*

**treatment while participating in an Student Observational/Internship Experience at the University of Connecticut Health Center, I, the undersigned, hereby give my consent for any medical and/or surgical treatment as the attending physician and/or surgeon deems necessary. This includes the giving of anesthetics.**

**I have read the above and understand it, and grant permission.**

\_\_\_\_\_  
 \_\_\_\_\_  
*Signature, Parent or Legal Guardian*  
*Relationship*

Revised: 4/09

**Host/Preceptor/Manager place copy in student file, send original to Office of Research Safety MC3930**

**Safety Clearance Form – for Minor Student’s and/or Minor Volunteers**

**TO BE COMPLETED BY PI/PRECEPTOR HOSTING MINOR STUDENTS OR VOLUNTEERS**

**FORM G Revised: 4/09**

**2009-2010**

Directions: **PI/Preceptor/Host must complete this form and return to the Office of Research Safety PRIOR to the onset of the student or volunteer experience. It is to be completed for minors only (age less than 18 years). The signatures indicates that the minor (student or volunteers) will not be exposed to any industrial hazards (e.g. bloodborne pathogens, chemicals, and/or radiation)**

**TO: P. I. Preceptor/Host/Manager:**

\_\_\_\_\_

**Room Number:**

\_\_\_\_\_

**Extension:** \_\_\_\_\_

**UCHC Sponsoring Program:**

\_\_\_\_\_

**Student’s Name:** \_\_\_\_\_ **Phone/Extension:**

\_\_\_\_\_

Your effort in acting as a preceptor for this minor plays a most important role in the continued success of the mission of the UCHC. For success we must also stress and solicit your help in assuring that the minor has a safe experience at the Health Center. As you supervise this minor, or have others assist you in supervising the minor, please keep in mind the guidelines below that must be followed:

- ◆ This minor may not fully appreciate the potential hazards associated with the activities he/she may observe. Thus, you must play an active role in monitoring the activities and setting appropriate limits for safety.
- ◆ Any activity of this minor must be accomplished so that he/she remains an observer. The minor may not be put in a position where direct contact with or exposure to human materials or infectious agents or exposure to hazardous quantities of dangerous materials (chemicals, ionizing or non-ionizing radiation, etc.) is possible. Personal protective equipment must not be relied upon to provide such exposure protection.
- ◆ The minor has not received laboratory safety training on the safe use or handling of chemicals, radioactive materials, human blood and body fluids, compressed gases, cryogenic materials, x-ray producing equipment, lasers, etc. You must establish appropriate controls and exercise supervision so that the risk of exposure is minimal.
- ◆ Confidentiality issues are of concern. You must ensure that the student does not have unauthorized access to patient records, diagnosis, etc., and that the “Patient Confidentiality Agreement” has been signed.

**Please review these guidelines with your minor or minor(s) and others that may assist you with your duties as a Preceptor. (Questions should be referred to the Office of Research Safety x2723). After you have reviewed the above information with the student, sign below and have any other preceptors and the student that you will supervise sign where indicated.**

**P.I. / Preceptor Signature/Date:**

\_\_\_\_\_

- ◆ Signatures/Date of others that will assist with supervision:

\_\_\_\_\_  
\_\_\_\_\_

Minor Signature/Date:

\_\_\_\_\_

**Host/Preceptor/Manager keep copy of form in student file, return original form to the Office of Research Safety - MC 3930**

**Rev. 6/06, 6/07, 4/08, 4/09**

**FORM H 2009-2010**  
**General Safety Information**  
**For Minors with Potential Exposure to**  
**Industrial Hazards**

The Health Center has a policy on minors in the workplace that will be found on page 180 of the UCHC Phone Book and in the “Safety” shared e-mail folders. In addition, for employees that are under 18 years of age, there are also special Connecticut and Federal regulations that apply *if the minor student receives compensation for the scheduled activity*.

Guidance follows on how to comply with these regulations and others so that laboratory risks are appropriately reduced while allowing the participants to fully benefit from this important program/grant.

- All participants in this program must receive UCHC Laboratory, Radiation and Bloodborne Pathogen Training before assignment to the host or doing work in the host’s laboratory. Radiation Safety and Bloodborne Pathogen Training is given as informational with the qualification that work with human materials/infectious agents, radioactive materials and radiation producing equipment (i.e., x-ray) is not permitted except with advanced coordination and prior written approval of the Research Safety Office or the Radiation Safety Committee, as appropriate (this approval is not necessary just because a laboratory works with these materials, the approval is necessary when the program participant works with such materials or will have such potential exposures).
- All participants must have a signed parental consent on file prior to assignment to the laboratory. This consent must be based on the parent(s) being informed about the type of work that will be done, the laboratory risks, and controls that will be taken to reduce these risks. The Office of Research Safety will be responsible for keeping on file the parental consent.
- The host (P.I. and P.I.’s staff) will need to accept responsibility for the supervision of the participant. Work with chemicals should be limited to those the host has authorized. Such use needs to be in accordance with the safety practices outlined by the host to the participant and the UCHC Chemical Hygiene Plan (available on the UCHC Web Homepage and from the Research Safety Office).
- The CT Labor Department (Workplace Conditions) will pre-inspect the laboratory *if the student is compensated for the activity*. The inspector will be accompanied by a representative from the Research Safety Office. *Allow a minimum of 6 weeks lead time if the lab requires a DOL inspection!* The focus of this inspection will be to insure that good safety practices are in place. Prior to the inspection, the P.I./P.I. staff should take a critical look, with the assistance of the Office of Research Safety (x2723), at the laboratory to insure among other issues:
  - good housekeeping
  - gas cylinders secured
  - eyewash functioning

- electrical hazards eliminated
- flammables properly stored inside cabinets
- other chemicals properly stored
- personal protective equipment availability (laboratory coats, safety glasses/goggles, faceshield, etc.)
- personal hygiene (soap, paper towels, etc. for handwashing)
- If radioactive materials are in use when the participant is present, an individual knowledgeable about its use should be present.
- When the participant arrives, the attached P.I.'s Checklist should be completed with the participant whether the minor is compensated or not.

Attachment

**Safety Checklist for Minor (Student or Volunteer)  
With Potential Exposure to Industrial Hazards**

Minor Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Is Minor a Volunteer or Student? \_\_\_\_\_

If Student, what is source school? \_\_\_\_\_

P.I. / Preceptor Name: \_\_\_\_\_ Written Initials: \_\_\_\_\_

FORM H: Revised 4/09 2009-2010

Action Item	Employee's Initial	P.I. Initials Indicating Completion
1. Minor attends Laboratory Safety, Bloodborne Pathogen and Radiation Safety Training during their initial orientation. Have them verbally acknowledge this and ask if they have any questions.		
2. Outline to the participant the work restrictions* that include: <ul style="list-style-type: none"> <li>a. Use of autoclaves</li> <li>b. Disposal of hazardous wastes, except as directed by P.I.</li> <li>c. Work with hazardous chemicals except for those used in the quantities and manner approved by the P.I.</li> <li>d. Activities or work with unfixed human materials and other potentially infectious materials that could result in potential exposure (splash, contaminated sharps, etc.) irrespective of any personal protective equipment use</li> <li>e. Use of lasers or systems containing lasers</li> <li>f. Work with radioactive materials and/or radiation producing equipment (i.e., x-ray)</li> <li>g. Other Departmental restrictions</li> </ul> <p>* In some cases restrictions d, e and f may be removed or modified. This takes advanced coordination and written approval by the Research Safety Office or Radiation Safety Committee, respectively.)</p>		
3. Outline location and use of emergency eyewash and location of emergency shower (without shower activation). Stress that in case of contact with a hazardous material, flush that body area with copious amounts of water.		
4. Brief minor on emergency evacuation procedures, the location of the laboratory assembly point and the dialing of x7777 for emergency assistance.		
5. Brief minor that in case of a spill that they are: to minimize their exposure, not clean it, and promptly seek assistance from the P.I./Preceptor staff.		
6. Provide at no cost to the minor appropriate personal protective equipment. In many cases, this may be only a clean laboratory coat that can be sent to a UCHC paid laundry service when dirty and ANSI approved safety glasses with sideshields (available from the Warehouse, item #85613 at \$1.66). The participant should not be doing tasks with potential for a liquid splash of hazardous materials. Thus, the need to issue safety goggles would not normally be anticipated.		
7. Gloves, outline when and what gloves to use and provide these at no cost.		
8. Emphasize that no food or drink is allowed in laboratory areas where chemicals, radioactive materials and human materials/infectious agents are used.		
9. Outline their authorized activities and work, the potential risks and the procedures and equipment that must be followed to minimize those risks. Specific items covered may be listed below.  _____		
10. Designate yourself (and a staff member if possible) as responsible for supervising the minor and answering questions.		

11. Outline the UCHC mandates for prompt reporting of any injury or exposure that may effect health. The minor must report this BOTH to the P.I. / Preceptor and by phone to Human Resources (Ann Smith x2523 or Sandy Kressner x3419) or Susan Manzi at x 2826 if the minor is a volunteer). Medical evaluation would be by Employee Health Service (3 <sup>rd</sup> floor, Dowling North, M-F, 8:00 AM – 5:00 PM) or for emergencies and at other times the Emergency Department.		
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**Keep copy of form in student file, return original form to the Research Safety Office**

**MC 3930**

**8/13/01 (safetymin.doc) Rev. 6/06, 6/07, 4/08, 4/09**

## Safety Checklist for Minor (Student or Volunteer) With Potential Exposure to Industrial Hazards

**Minor Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Is Minor a Volunteer or Student?** \_\_\_\_\_

**If Student, what is source school?** \_\_\_\_\_

**P.I. / Preceptor Name:** \_\_\_\_\_ **Written Initials:** \_\_\_\_\_

### FORM H 2007-2008

Action Item	Employee's Initial	P.I. Initials Indicating Completion
12. Minor attends Laboratory Safety, Bloodborne Pathogen and Radiation Safety Training during their initial orientation. Have them verbally acknowledge this and ask if they have any questions.		
13. Outline to the participant the work restrictions* that include: <ul style="list-style-type: none"> <li>h. Use of autoclaves</li> <li>i. Disposal of hazardous wastes, except as directed by P.I.</li> <li>j. Work with hazardous chemicals except for those used in the quantities and manner approved by the P.I.</li> <li>k. Activities or work with unfixed human materials and other potentially infectious materials that could result in potential exposure (splash, contaminated sharps, etc.) irrespective of any personal protective equipment use</li> <li>l. Use of lasers or systems containing lasers</li> <li>m. Work with radioactive materials and/or radiation producing equipment (i.e., x-ray)</li> <li>n. Other Departmental restrictions</li> </ul> <p>* In some cases restrictions d, e and f may be removed or modified. This takes advanced coordination and written approval by the Research Safety Office or Radiation Safety Committee, respectively.)</p>		
14. Outline location and use of emergency eyewash and location of emergency shower (without shower activation). Stress that in case of contact with a hazardous material, flush that body area with copious amounts of water.		
15. Brief minor on emergency evacuation procedures, the location of the laboratory assembly point and the dialing of x7777 for emergency assistance.		
16. Brief minor that in case of a spill that they are: to minimize their exposure, not clean it, and promptly seek assistance from the P.I./Preceptor staff.		
17. Provide at no cost to the minor appropriate personal protective equipment. In many cases, this may be only a clean laboratory coat that can be sent to a UCHC paid laundry service when dirty and ANSI approved safety glasses with sideshields (available from the Warehouse, item #85613 at \$1.66). The participant should not be doing tasks with potential for a liquid splash of hazardous materials. Thus, the need to issue safety goggles would not normally be anticipated.		
18. Gloves, outline when and what gloves to use and provide these at no cost.		
19. Emphasize that no food or drink is allowed in laboratory areas where chemicals, radioactive materials and human materials/infectious agents are used.		
20. Outline their authorized activities and work, the potential risks and the procedures and equipment that must be followed to minimize those risks. Specific items covered may be listed below.  _____		
21. Designate yourself (and a staff member if possible) as responsible for supervising the minor and answering questions.		

22. Outline the UCHC mandates for prompt reporting of any injury or exposure that may effect health. The minor must report this BOTH to the P.I. / Preceptor and by phone to Human Resources (Ann Smith x2523 or Sandy Kressner x3419) or Susan Manzi at x 2826 if the minor is a volunteer). Medical evaluation would be by Employee Health Service (3 <sup>rd</sup> floor, Dowling North, M-F, 8:00 AM – 5:00 PM) or for emergencies and at other times the Emergency Department.		
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**Return completed form to the Research Safety Office MC 3930 and keep a copy in the student's file**

**8/13/01 (safetymin.doc)**

STUDENT SERVICES REQUEST/POSITION DESCRIPTION  
**FORM I: Revised 4/09**  
**2009-2010**

**Directions: Please complete this form when requesting a student affiliation (compensated or not compensated) in an area that has potential industrial exposure (for example; laboratory, radiation area, etc.). Any questions regarding completion of the form should be directed to Office of Research Safety – 679-2723. Once the form is complete please forward to Office of Research Safety at MC – 3930. All required training, as identified on this form, must be coordinated by the student host (manger/supervisor/PI)**

**Part I:**

Department/Division:		Ext:	
Person/Dept. Requesting Student/Minor Service		Date:	
Title:	Office Location:	M.C.	Fax:
Why do you want minor/student assistance?			
Individual Required (Check as many as are acceptable)		Adult: <input type="checkbox"/>	College: <input type="checkbox"/> High School * (age 15 or older): <input type="checkbox"/>
Date of Birth ___/___/___			
<p><small>* Requestors and their departments have responsibilities to review and monitor the activities of students so that risks from potential hazards are eliminated or appropriately managed. Minors (under 18 years of age) are prohibited from entry into laboratories, industrial areas and rooms that must be entered by passing through such rooms (see UCHC Policy on Minors in the Workplace). In situation where a structured educational program has been established and the minor is participating in such an educational program, a minor at least 15 years may enter such areas after: obtaining a signed contract between UCHC and the school, obtaining an informed parental consent to participate in the program; the program/department has assigned the host/instructor responsibilities to appropriately reduce risks and supervise the activities of the minor and verified that these responsibilities have been accepted; and, the program/department has determined any additional requirements from Employee Health Services and the Research Safety Office. <b>All persons requesting student service <u>MUST</u> circle the appropriate answers to the questions on the back of this form:</b></small></p>			
Student's Name:		Room #:	
Where will the student work?		Is the workstation wheelchair accessible?	
Who will train and supervise the student?		Ext:	
Days preferred:	Number of days per week:		
Hours needed:	How many students can you accept?		
Start date:	End date:		
Brief, specific description of what the student will be required to do (List duties):			
Qualifications:			
If specialized training is required, who will provide it? What will it consist of?			

**CONTINUE ON BACK**

## Part II (Circle Appropriate Answer):

YES	NO	1. Will the student work in a laboratory? (If yes, contact the Office of Research Safety, Laboratory Safety Training must be completed).
YES	NO	2. Will the student work in a non-laboratory area with the potential for exposure to hazardous chemicals? (If yes, contact the Office of Research Safety, General Chemical Safety Training must be completed).
YES	NO	3. Will the student work with or in an area with radioactive materials, equipment producing ionizing radiation, or lasers? (If yes, contact the Office of Research Safety, Radiation Safety Training must be completed)
YES	NO	4. Will the student work with laboratory animals? (If yes, Animal Care Training must be completed. Contact ACC Office at: <a href="mailto:OOACC@uchc.edu">OOACC@uchc.edu</a> to arrange this).
YES	NO	5. Will the student be exposed to human blood or infectious materials? (Minimum age 16 years old.) (If yes, contact the Office of Research Safety, Bloodborne Pathogen Training must be completed).
YES	NO	6. Will the student require personal protective equipment? (If yes, then the student's supervisor must provide it, train the student in its proper use, and inform the student about the tasks requiring such use).
YES	NO	7. Is the student a minor (under 18)? (If yes, complete Part III. If no, go the Part IV.)

## Part III - Minors (Circle Appropriate Answer):

YES	NO	1. Is the minor at least 15? (If no, the minor is prohibited from entry into laboratories and industrial areas.
YES	NO	2. Is this student assignment part of a structured education program? (If no, the minor is prohibited from entry into laboratory and industrial areas. If yes, enter name of the educational program _____ and verify by signature on this form that a signed contract with the school has been executed and all other requirements have been met.  Will Minor be Compensated? YES NO      Signature: _____  <b>If minor will be compensated the Connecticut Department of Labor must inspect the work area prior to initiation of work. Working papers are also required. Call the Research Safety Office for further information x 2723. Allow at least 6 weeks lead time for this inspection!!!</b>
YES	NO	3. Is the minor at least 16? (If no, work with potential exposure to ionizing radiation, lasers and infectious agents including human blood and body fluids is prohibited. If yes, see items 3 and 5 in Part II.)
YES	NO	4. Attached is a description of duties, potential risks and outline of the structured educational program signed by the P.I. or Department Head that will be used as part of the parental consent form.

## Part IV

This assignment is for:	A limited time period: <input type="checkbox"/>	Ongoing: <input type="checkbox"/>	Begins:	Ends:
<b>Signature of Requester:</b>				<b>Date:</b>
<b>Signature of Department Head*:</b>				<b>Date:</b>
* The above signature of Department Head indicating that they have approved the experience, provided for all safety training and verified that all documentation requirements have been met.				

**Keep copy of form in student file, return original to the Office of Research Safety MC3930**

Revised: 6/06, 6/07, 4/08, 4/09



# University of Connecticut Health Center

## Form J: Certification of Non-Discrimination

### CERTIFICATION

*(By corporate or other business entity regarding support of nondiscrimination against persons on account of their race, color, religious creed, age, marital or civil union status, national origin, ancestry, sex, mental retardation, physical disability or sexual orientation.)*

I \_\_\_\_\_ (signer's name), \_\_\_\_\_ (signer's title) of \_\_\_\_\_ (name of entity) \_\_\_\_\_, an entity lawfully organized and existing under the laws of \_\_\_\_\_ (name of state or common-wealth) \_\_\_\_\_, do hereby certify that the following is a true and correct copy of a resolution adopted on the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_ by the governing body of \_\_\_\_\_ (name of entity) \_\_\_\_\_, in accordance with all of its documents of governance and management and the laws of \_\_\_\_\_ (name of state or commonwealth) \_\_\_\_\_, and further certify that such resolution has not been modified, rescinded or revoked, and is, at present, in full force and effect.

RESOLVED: That \_\_\_\_\_ (name of entity) \_\_\_\_\_ hereby adopts as its policy to support the nondiscrimination agreements and warranties required under Connecticut General Statutes § 4a-60(a)(1) and § 4a-60a(a)(1), as amended in State of Connecticut Public Act 07-245 and sections 9(a)(1) and 10(a)(1) of Public Act 07-142.

IN WITNESS WHEREOF, the undersigned has executed this certificate this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_.

By : \_\_\_\_\_

Print Name:

Title: \_\_\_\_\_

Effective June 25, 2007

Revised: 4/09