Nursing Research Essentials Checklist

<https://www.baptistonline.org/gradnurse-application>

***Project Packet***

Baptist Memorial Health Care

**ON-Line APPLICATION – Project Site** – Complete and Submit to Project Site Research Coordinator :

1. System Nursing – Baptist Memorial Health Care (*BMHC*) – Arkansas, TN, Mississippi, and BMG – On-Line BMHC Research Coordinator is Dr. Diana Baker @ [Diana.Baker@BMHCC.org](mailto:Diana.Baker@BMHCC.org)
2. Mississippi Baptist Medical Center (*MBMC*) -- Jackson MS -- MBMC Research Coordinator is Dr. Tina Magers @ [Tina.Magers@BMHCC.org](mailto:Tina.Magers@BMHCC.org)

*Identify the project as defined by one of the following – Consult with your School faculty* ***– circle, a, b, c***

* 1. Evidence Based Practice **--**  A problem-solving approach to clinical decision-making within a health care organization that integrates the best available scientific evidence with the best available experiential (*patient and practitioner)* evidence, considers internal and external influences on practice, and encourages critical thinking in the judicious application of such evidence to care of the individual patient, patient population, or system.
  2. Nursing Research– A systematic investigation, including research development, testing, and evaluation, designed to develop or contribute to generalizable knowledge
  3. Quality Improvement -- is a process by which individuals work together to improve systems and processes with the intention to improve outcomes.

*Submit All FORMS or questions, please contact IRB Coordinators:*

* + *Mildred Jenkins at 901-226-1678 -- Mildred.Jenkins@BMHCC.org*
  + *Tracey Smith at 901-226-1677 – Tracey.Smith2@BMHCC.org*
  + *Please attempt to scan in your forms, certificates, and papers as one document before emailing.*
  + ***Include your first initial and last name in all file names****.* ***For example, “JDoe IRB Proposal.pdf”***

**INSTRUCTIONS**

* FORMS – there are examples of noted forms in the ADDENDA

Title: School IRB Approval -- OBTAIN FROM SCHOOL FACULTY

Title: NIH FCOI Tutorial – OPEN LINK -- *Specific from the NIH*

[**https://grants.nih.gov/grants/policy/coi/tutorial2018/story\_html5.html**](https://grants.nih.gov/grants/policy/coi/tutorial2018/story_html5.html)

Title: Baptist Financial Conflict of Interest Form – OPEN LINK -- *Similar to a form needed to apply for meeting an expectation*

[**https://sites.bmhcc.org/clinicalresearch/**](https://sites.bmhcc.org/clinicalresearch/)

A new FCOI form is required annually while the project is in progress

Title: Required CITI Training – OPEN LINK – *You may have completed at school and already have a certificate*

[**https://about.citiprogram.org/en/homepage/**](https://about.citiprogram.org/en/homepage/) **IRB Staff will receive notification once student has been completed CITI Training.**

Title: HIPAA Training Acknowledgement – Student -- CHECK ADDENDA -- *see form*

Title: BMH Confidentiality Form -- CHECK ADDENDA -- *see form*

Title: Data Request Form – CHECK ADDENDA – *see form*

Title: Final Report – Study Closure - -OPEN LINK – *Applications and forms -- Title – Final Report Study Closure*

[**https://www.baptistonline.org/services/clinical-trials-research/hrrp-and-irb**](https://www.baptistonline.org/services/clinical-trials-research/hrrp-and-irb)

***CHOSE ONE IRB APPLICATION -- Consult with your School faculty***

Title: Exempt from IRB Review – OPEN LINK

[**https://www.baptistonline.org/-/media/IRB-Website/2018-2019-Files/IRBExempt-from-IRB-Review-Application-Research-or-QI-Project.docx?la=en**](https://www.baptistonline.org/-/media/IRB-Website/2018-2019-Files/IRBExempt-from-IRB-Review-Application-Research-or-QI-Project.docx?la=en)**;**

Title: Application for Students and Residents, Using Existing Medical Records -- OPEN LINK

[**https://www.baptistonline.org/-/media/IRB-Website/2018-2019-Files/IRB-Application-to-Conduct-Research-Using-Existing-Medical-Records-Residents-Students.docx?la=en**](https://www.baptistonline.org/-/media/IRB-Website/2018-2019-Files/IRB-Application-to-Conduct-Research-Using-Existing-Medical-Records-Residents-Students.docx?la=en)

Title: Application to Conduct Human Subject Research - -OPEN LINK – *Applications and forms -- Title – Initial Application for conduct Human Subject* ***Research*** *– DNP and PhD students need to check*

[**https://www.baptistonline.org/services/clinical-trials-research/hrrp-and-irb**](https://www.baptistonline.org/services/clinical-trials-research/hrrp-and-irb)

**MEMORANDUM OF UNDERSTANDING (*MOU*)**

1. Exhibit A – Will include the Baptist Institutional Review Board (*IRB*) Letter of Determination (*for the project*).
   1. Content of Letter of Determination
      1. Approved
      2. Revisions needed
      3. Not Approved
2. MOU: After the Letter of Determination is received by the student from the BMH IRB, a fully executed MOU will be generated and sent by the Nursing Research Coordinator to the applicable Baptist facility to obtain respective signatures.
3. MANADATORY – Completed MOU will need to be on file with Research Coordinators, Baptist IRB, Baptist Corporate Legal, affiliating Baptist facility and student School before project can be implemented.

**FORMS ADDENDA**

BMH – Confidentiality

Data Request

HIPAA Acknowledgement

# BAPTIST CONFIDENTIALITY STATEMENT

Baptist and its affiliated entities (“Baptist”)protect the privacy of patients and their families, Baptist employees, and students of Baptist College of Health Sciences, including safeguarding confidential and/or proprietary information. Baptist’s Confidential Information Policy (CIP) protects any information – verbal, written, or electronic. Maintaining confidentiality is a required duty of anyone with access to Baptist’s confidential information.

BY SIGNING THIS CONFIDENTIALITY STATEMENT, I UNDERSTAND AND ACKNOWLEDGE THAT:

1. I am aware of Baptist’s CIP and I have had the opportunity to review the policy.
2. I realize that I can ask for clarification of the policy, or report violations of confidentiality by calling the Baptist Helpline/Hotline at 1-877- BMH-TIPS.
3. I understand it is my responsibility to:

* Comply with the Baptist Confidential Information Policy;
* Maintain the confidentiality of all patient medical records, employee information, financial information, proprietary information, and other confidential information (information) arising from or pertaining to Baptist;
* Understand that each time I access protected health information (PHI) I will only use the minimum necessary required for my job;
* Not access data on patients for whom I do not have responsibility and/or for whom I do not have a “need to know.” I am aware that computers and their applications have audit trails, which track access to patient information;
* Keep information confidential and not disclose it to others, including employees, patients, and patient’s family members, without proper authorization;
* Agree to discuss information only in the work place as appropriate, and only for job related purposes, and to refrain from discussing this information outside of the work place or within the hearing of other people who do not have a need to know about the information;
* Refer all requests and inquiries for confidential information to those within Baptist who are responsible for release of information.
* Only print PHI as required to perform my job duties.
* I will follow appropriate safeguards regarding the transport of PHI (i.e. from home to entity, within entity or entity to entity). PHI will remain in my immediate personal possession at all times and will be disposed of in accordance with Baptist policy (i.e., placed in a container to be shredded).
* If approved, any PHI that is printed at an offsite location, such as my home or office, I will diligently maintain PHI in a secure manner so that it cannot be accessed by unauthorized individuals such as family members, conference attendees or general public. PHI is not left unattended in publicly-accessible locations.
* I will immediately report to the Corporate Privacy & Security office any PHI that is lost, stolen, accessed or viewed by unauthorized individuals, or is otherwise compromised, upon coming aware of.

1. If I am given access to Baptist computer system(s), I understand it is my responsibility to:

* Understand that my computer access code (password, personal identification number) is the equivalent of my legal signature.
* Keep secret all computer identifiers, passwords, PIN numbers and access codes issued to me.
* Contact Information Technology or their designee to have my code deleted and a new code issued if I have reason to believe that the confidentiality of my computer access code has been breached.
* Promptly signoff after each computer session to prevent unauthorized use of the application.

1. **Medical Staff Members:** If I am a credentialed member of the medical staff, I understand that any misuse of my confidential access code or inappropriate use of any of Baptist computer systems is a violation of 1) the Medical Staff Bylaws, Procedures, Rules and Regulations, or my Professional Services Agreement, and 2) may result in disciplinary action being taken by the governing Board, and 3) may additionally have legal and/or regulatory penalties.
2. **Others with access to confidential information:**  I understand that a violation of these requirements may result in disciplinary action up to, and including, termination of my employment, affiliation, and/or contractual rights with Baptist, and/or disciplinary action as well as any penalties prescribed by law. I understand and agree that this obligation continues in effect after I am no longer an employee or affiliate of Baptist. I further understand and agree that Baptist may take legal action to enforce this obligation.
3. If I am a user of Baptist OneCare or other Baptist-provided systems, I have read and understand all applicable Terms of Service governing my access to and use of the system(s). I further agree to all of the conditions contained in the Terms of Service and by signing below I acknowledge and ratify my electronic acceptance of the Terms of Service. I further understand that my password is unique and *I cannot divulge it to anyone else and I must take extraordinary steps to keep my password secret*. I further understand and agree that I am responsible for any misuse of my password, by myself or anyone else who gains access to my password because I shared it or failed to take proper steps to safeguard it.

(Check your affiliation with Baptist and complete identifying information.)

Employee Physician Allied Health Resident/Intern  Physician staff  Contractor Consultant

School Faculty Student Clergy Volunteer Agency Staff Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last 4 digits SSN: \_\_ \_\_ \_\_ \_\_

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

Department: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and/or Company/School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Data Request Form**

Date Request Submitted: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Requestor Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Institution: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Department/Office: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Check one: Baptist Employee private physician with Baptist privileges

Non-Baptist Employee Resident

Request type: New Report Modify Existing Report

System(s) Involved: Epic HPF Lawson All scripts ARIA Other

Please describe the reason for making this request: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Project Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IRB number (if applicable) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How will data being requested be used? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Who will have access to the data? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Will the data be sent outside Baptist?  Yes  No

If yes, method being sent: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has a security assessment been performed: Yes No\* N/A

Has the Corporate Privacy & Security department approved the data elements? Yes No\*

Have all the required agreements been executed? Yes No\*

Have you completed and submitted a Financial Conflict of Interest Form to Corporate Compliance department?  Yes  No\*\* N/A

\*if No, contact Corporate Privacy & Security at [CorporatePrivacySecurity@BMHCC.org](file:///C:\Users\bak4867\AppData\Local\Microsoft\Windows\Temporary%20Internet%20Files\Content.Outlook\PNV1WO6C\CorporatePrivacySecurity@BMHCC.org) before proceeding.

\*\* if No, contact Corporate Compliance at [FCOI@BMHCC.org](mailto:FCOI@BMHCC.org) or 901.227-5920 before proceeding.

|  |  |  |  |
| --- | --- | --- | --- |
| Please provide a detailed description of the data requested (check all that applies): | | | |
| **Name**  First  Middle  Last | **Full face photographic images and any comparable images** | **Current Medications**  Drug Dosage Route Quantity number Quantity form Frequency Start date Stop date Prescribed by Prescription date Prescription number Pharmacy Allergic reaction Source of medication list (pharmacy vs. patient or spouse) | **Allergies**  Allergy or sensitivity type Reaction Severity Date last occurred Treatment |
| **Initials** | **Any other unique identifying number, characteristic, or code except the unique code assigned by the investigator to code the data** | **Medications at**  **discharge**  Drug Dosage Route Quantity number Quantity form Frequency Start date Stop date Prescribed by Prescription date Prescription number Pharmacy | **General Appearance**  Body build Demeanor Hygiene |
| **Address** | **Gender** | **Physical examination** | **Operative diagnoses** |
| **Date of Birth** | **Race** | **Treatment goals** | **Preoperative**  **diagnoses** |
| **Date of Death** | **Reason for visit** | **Plan** | **Postoperative**  **diagnoses** |
| **Admission Date** | **Chief complaint** | **Procedures** | **Fax number(s)** |
| **Discharge Date** | **History of present**  **illness**  Symptom(s) Onset of symptom(s) Duration of symptom(s) Over-the-counter (OTC) treatment | **Past medical history** | **Phone number(s)** |
| [**Email**](https://en.wikipedia.org/wiki/Email)**address(es)** | **Account number** | [**Social Security number**](https://en.wikipedia.org/wiki/Social_Security_number) | [**Health insurance**](https://en.wikipedia.org/wiki/Health_insurance)  **beneficiary number(s)** |
| **Assessment**  Diagnoses  Disposition | **Condition type**  Date diagnosed Age of onset Treatment Condition status | **Diagnostic findings**  Laboratory Pathology Imaging Cardiovascular | **Test** Result/finding Result/finding date Interpretation |
| **Medical record**  **number** | **Social history**  Marital status Occupation Home environment Daily routine Dietary patterns Sleep patterns Exercise patterns Coffee consumption Tobacco use Alcohol use Drug use | **Family history**  Child health history Adult health history Hereditary diseases Mother health status Mother age of death Mother cause of death Father health status Father age of death Father cause of death Sibling(s) health status Sibling(s) age of death Sibling(s) cause of death | **Discharge**  Final diagnosis Condition on discharge Reason for discharge  Discharge instructions  Disposition patient instructions Follow-up action Follow-up target date |
| **HIV/STDs** | **Mental Health**  **issues** | **Pregnancy**  Number of pregnancies  Number of live births  Spontaneous abortion  Elective abortion | **Abuse**  Physical  Sexual |
| **Payer Mix** | **Immunizations** | **Childhood**  **immunizations**  Vaccine Vaccine type Dose Age administered Date administered Lot number Physician | **Adult immunizations**  Vaccine Vaccine type Dose Date administered Lot number Physician |
| **Certificate/license**  **numbers** | **Device identifiers and serial numbers** | **Web**[**Uniform Resource Locators**](https://en.wikipedia.org/wiki/Uniform_Resource_Locator)**(URLs)** | **Internet Protocol (IP) address numbers** |
| **Vehicle identifiers and serial numbers, including license plate numbers** | **Vital signs**  Pulse Respiratory rate Systolic blood pressure Diastolic blood pressure Body temperature Height Weight Body mass index Head circumference Crown-to-rump length Pulse oximetry | **Review of systems**  General  Skin  Head  Eyes  Ears  Nose and sinuses  Mouth and throat  Neck  Breasts   Respiratory  Cardiac   Gastrointestinal  Genitourinary  Gynecologic  Musculoskeletal   Peripheral vascular  Neurologic  Hematologic  Endocrine  Psychiatric | **Procedure history**  Procedure  Date  Physician  Institution/location  Result |
| **Operation**  Operation/procedures  performed  Operation description  Findings  Sedation/anesthesia  Complications  Drains  Estimated blood loss  Packs  Sutures  Patient condition  Discharge from  recovery care | **Physical findings**  Skin Head  Eyes Ears Neck  Nose/sinus Neurologic   Mouth and throat  Thorax, anterior, and  posterior Breasts  Lungs Cardiovascular  Abdome Mental status  Male genitourinary  Female reproductive  organs Ano-rectal  Musculoskeletal system  Extremities Lymphatics  Peripheral vascular | [**Biometric**](https://en.wikipedia.org/wiki/Biometric)**identifiers, including finger, retinal and voice prints** | **Other:** |

Please specify the time period desired: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ through \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please indicate the sorting/grouping preferences: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*By submitting this Data Request Form I certify that the requested data is part of my work function and I have appropriate approval to request and access said data. Furthermore, I certify that the Corporate Privacy & Security Department, Corporate Legal and Corporate Compliance, as applicable, have reviewed and approved my request.  Any and all required agreements related to this request are in place and attached hereto.*

Requestor signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**INTERNAL APPROVAL**

**Privacy** approval by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Security** approval by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Legal** approval by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Compliance** approval by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Required Agreement(s):**

Collaboration Agreement

Services Agreement

Data Use Agreement

Business Associate Agreement

Other

Please return this form via email to [Laura.Cummins@bmhcc.org](mailto:Laura.Cummins@bmhcc.org), Baptist.IRB@bmhcc.org. If you have any questions regarding this form, please contact Laura at (901)227-4058.

**HIPAA Training Acknowledgement**

**To be completed by the faculty advisor:**

I acknowledge that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (student’s name) has completed

HIPAA Privacy and Security training as provided by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Institution) on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (date).

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

Print Name Date

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

Signature