Non-MD Visiting Student

2018-2019 Appointment Checklist and Cover Sheet

Office of Graduate Medical Education, UCSF

Please fill out this form completely and attach to the complete appointment packet for submission to the GME Office at least one month prior to rotation start date. Please place all paperwork in the order listed on this form. Do not include any paperwork in this packet that is not listed below. Please submit all documents as single-sided documents with original signatures.

Student Name _____ UCSF Department _____

Program/Rotations _____ Date Packet to GME _____

UCSF Program Coordinator _____ Training Supervisor _____

UCSF Coordinator Email _____ UCSF Coordinator Phone _____

Document	Attached	GME Approved
Application for Elective Rotation	☐ Yes ☐ No	☐ Yes ☐ No
Proof of Medical Malpractice Coverage ***	☐ Yes ☐ No	☐ Yes ☐ No
Attestation (signed by trainee and Director)	☐ Yes ☐ No	☐ Yes ☐ No
Two PPDs or Chest X-Ray	☐ Yes ☐ No	☐ Yes ☐ No
Health Statement (signed by health care provider)	☐ Yes ☐ No	☐ Yes ☐ No
California Abuse Reporting Form	☐ Yes ☐ No	☐ Yes ☐ No
HIPAA Confidentiality Statement	☐ Yes ☐ No	☐ Yes ☐ No
Patent Acknowledgment	☐ Yes ☐ No	☐ Yes ☐ No
Waiver of Liability, Assumption of Risk, and Indemnity Agreement	☐ Yes ☐ No	☐ Yes ☐ No

*** Medical malpractice insurance must be provided by the student's home institution at a minimum of $1,000,000 per occurrence. A copy of the insurance certificate is the preferred documentation proof.***

Please explain any missing documentation.

GME Comments

NON-MD STUDENTS APPLICATION FOR ELECTIVE ROTATION UCSF MEDICAL CENTER

This application must be completed for non-medical students (those other than dentistry, pharmacy, and nursing students) who would like to participate in the care of UCSF Medical Center patients and whose involvement in patient care exceeds observation. For students who will only be observing patient care, please contact the Office of Graduate Medical Education for more information regarding the Visiting Scholars program. Please submit this application and all required supporting documentation (see checklist) to the Office of Graduate Medical Education at least one month prior to the rotation start date.

Section 1 - To be completed by visiting student:

_____ _____
Student's Name Degrees Earned (if applicable)

_____ _____ _____ _____
Date of Birth Social Security Pager Number Home Phone

_____
Home Address

I _____ ("Trainee") understand that this rotation/clinical experience is being made

available to me pursuant to the terms of an agreement between UCSF and _____ (home institution) based upon their mutual interest in training health care professionals. I understand that this experience is solely for my educational benefit and that my status is that of a trainee. I understand and acknowledge that I do not have an employment or volunteer relationship with UCSF and that I will not be providing any services to UCSF during the course of my rotation/clinical experience.

Student Signature: _____ Date: _____

Section 2 - To be completed by student's home institution:

Contact Person/Program Coordinator: _____ Phone number: _____

Program Director/Supervisor: _____ Phone number: _____

_____(student's name) is a _____ year student in good standing in

_____(program) at _____(name of institution),

_____(institution address).

This student is authorized to participate in the below listed elective rotation(s) at the University of California, San Francisco.

Home Institution Signatures:

Supervisor/Division Chief: _____ Date: _____

Department Chair: _____ Date: _____

Section 3 - To be completed by UCSF Department:

UCSF Contact Person/Program Coordinator: _____ Phone number: _____

UCSF Training Supervisor: _____ Phone number: _____

The above named student would like to apply for an Elective Rotation in the UCSF Department of _____

in _____ (division or program), for the period

from _____ to _____ at (hospital) _____ (location/ward) _____ % _____

from _____ to _____ at (hospital) _____ (location/ward) _____ % _____

Description of program: _____

_____

_____

Description of the nature of patient contact: _____

_____

_____

UCSF Signatures:

Supervisor of Training: _____ Date: _____

Department Chair: _____ Date: _____

Name (Last, First Middle) _____ **Social Security Number** _____

Candidate for House Staff (Re-)Appointment

Any "yes" response to the questions below requires a detailed explanation on a separate page. Failure to provide an adequate explanation may result in the delay or rejection of your (re)appointment.		
1. Has any medical malpractice judgment been entered against you in any professional liability case(s)?	Yes	No
2. Has any settlement been made in any professional liability case in which you or your insurance carrier had to or agreed to make a monetary payment?	Yes	No
3. Are you aware of any malpractice claims currently pending/under investigation against you?	Yes	No
4. Has any policy been canceled, or has any professional liability insurer refused to renew your policy or placed limitations on the scope of your coverage?	Yes	No
5. Do you currently have, or have you had a problem associated with the use or misuse of drugs or controlled substances of any kind (whether obtained by prescription or otherwise), or alcohol? If yes, on a separate sheet please give a full explanation, including, without limitation, frequency and amount of use, the time period in which you engaged in such use, and the date last used.	Yes	No
6. Do you have any reason you cannot safely perform all the essential mental and physical functions related to the specific clinical privileges you are requesting or required by your agreement with your training program and the School of Medicine, with or without reasonable accommodation, according to accepted standards of professional performance, and without posing a significant health and safety risk to others? If yes, on a separate sheet, please describe the essential function(s) and state the reason why you may not be able to safely perform it.	Yes	No
7. Voluntarily or involuntarily, have any of the following ever been, or are currently being, denied, revoked, suspended, relinquished, withdrawn, reduced, limited, placed on probation, not renewed, or currently pending/under investigation?		
Medical/Psychology license in any state	Yes	No
Other professional registration/license	Yes	No
DEA Certificate of registration	Yes	No
Academic appointment	Yes	No
Membership on any hospital medical staff	Yes	No
Clinical privileges, prerogatives/rights on any medical staff	Yes	No
Board Certification	Yes	No
Any other type of professional sanction	Yes	No
8. Have you been subject to any disciplinary action in medical school or a post-graduate training program, or in any health care organization or medical society, or is any such action pending?	Yes	No
9. Has any monitoring requirement been imposed?	Yes	No
10. Have you resigned or taken a leave of absence in order to avoid possible revocation, suspension, or reduction of privileges at any hospital, institution, or training program?	Yes	No
11. Have there been any, or are there any, misdemeanor or felony criminal convictions against you, or charges pending against you, including those under the Criminal Control Act?	Yes	No
12. Are there any pending or completed administrative agency, government, or court cases, decisions or judgments involving allegations that you failed to comply with laws, statutes, regulations, or other legal requirements that may be applicable to the practice of your profession or to your rendition of service to patients?	Yes	No
13. Are there any prior or pending government agency or third party payer proceedings or litigation challenging or sanctioning your patient admission, treatment, discharge, charging, collection, or utilization practices, including, but not limited to, Medicare Medicaid fraud and abuse proceedings or convictions?	Yes	No

My signature below indicates that I have provided complete and truthful information and answered the questions on this page completely and honestly. I give permission for UCSF to validate any of the information provided above and in my CV, including, but not limited to, previous training, previous medical staff appointments, and medical degree, at any time.

_____ _____

Candidate Signature Date

UCSF Program Director

My signature below indicates that I have reviewed this candidate's responses to the questions and recommend him/her for housestaff (re-)appointment.

_____ _____

UCSF Program Director Signature Date

UCSF Medical Center

ADULT/CHILD ABUSE AND DOMESTIC VIOLENCE REPORTING REQUIREMENTS

California law requires that medical practitioners, non-medical practitioners, health practitioners and child care custodians working in specified public or private facilities be informed of their duty to report suspected child abuse, suspected dependent adult abuse, and suspected domestic violence. Please read the following carefully and sign where indicated:

Section 11166 of the Penal Code requires any child care custodian, medical practitioner, non-medical care practitioner or employee of a child protective agency who has knowledge of or observes a child his or her professional capacity or within the scope of his or her employment whom he or she suspects has been the victim of a child abuse to report the known or suspected instance of child to a child protective agency immediately or as soon as practically possible by telephone and to prepare and send a written report thereof within 36 hours of receiving information concerning the incident.

Any person who fails to report an instance of child abuse which he or she knows to exists or reasonably should know to exist, as required, is guilty of misdemeanor and is punishable by confinement in the county jail for a term not to exceed six months or by a fine of not more than one thousand dollars ($1,000) or by both.

The law also provides that a person who does not report as required, or who provides a child protective agency with access to a victim, shall not be civilly or criminally liable for doing so.

Section 15630 of the Welfare and Institutions Code requires any care custodian, health practitioner, or employee of a health facility who is in his or her professional capacity, or within the scope of his or her employment of a health facility who is in his or her professional capacity, or within the scope of his or her employment, has knowledge of or observes a dependent adult who he or she knows has been the victim of physical abuse, or who has injuries is under circumstances which are consistent with abuse, to report the known or suspected instance of physical abuse to an adult protective services, agency or a local law enforcement agency immediately, or as soon as practically possible, by telephone, and to prepare and send a written report thereof within 36 hours of receiving the information concerning the incident. Reporting is required where the dependent adult's statements indicate, or in the case of a person with developmental disabilities, where his or her statements or other corroborating evidence indicates that abuse has occurred.

Sections 11160-11163 of the California Penal Code require that any health practitioner employed in a health facility, clinic or physician's office who, in his or her professional capacity or within the scope of his or her employment, has knowledge of or observes a patient whom he or she knows or reasonably suspects has suffered from any wound or injury inflicted as a result of domestic violence or spousal abuse shall immediately, or as soon as is reasonably possible, file a telephone report to the local law enforcement agency followed by a written report within two working days.

Failure to comply with these reporting requirements may lead to a fine up to $1,000 and/or six months in jail.

A health practitioner who makes a report in accordance with this article shall not incur civil or criminal liability as a result of any report required or authorized by this article.

I certify that I have read and understand this statement and will comply with my obligations under the dependent adult abuse, child abuse, and domestic violence reporting laws.

	NON-MD VISITING TRAINEE
Name (Please Print)	Position
Signature	Date

UNIVERSITY OF CALIFORNIA SAN FRANCISCO
SCHOOL OF MEDICINE, GRADUATE MEDICAL EDUCATION

2018–2019 HEALTH STATEMENT FOR NON-MD VISITING TRAINEES

NON-MD VISITING TRAINEE

First Name | Middle Name | Last Name | Work Status (Please Circle One)

Social Security Number | Department | Date of Birth | Gender

Email | Phone Number | Pager | Job Class

Date Form Completed

YOU MUST COMPLETE THESE FORMS IN FULL, REGARDLESS OF WHETHER YOU PROVIDE ADDITIONAL DOCUMENTATION. ONLY COMPLETE FORMS WILL BE ACCEPTED.

- **The attached "Pre-Placement Health Statement" and "TB Skin Test Reporting Form" should be completed by your primary care provider (or the Student Health Service of your medical school) prior to the start date of your appointment. Failure to comply will delay processing of your UCSF Resident/Clinical Fellowship appointment.**
- A **physical examination** must be performed under the direction of a physician as a condition of employment in a hospital. The individual to be employed should be free of symptoms that indicate the presence of an infectious disease.
- **Immunity to rubella, measles, mumps, and varicella is required**. The required screening tests and/or vaccinations are identified on the attached "Pre-placement Health Statement for New Residents and Fellows."
- A safe and effective vaccine is available for hepatitis B. Although **immunization for hepatitis B** is not required, it is strongly recommended. If the hepatitis B vaccination has not been acquired or if a positive titer result has not been obtained, then the attached declination form must be completed.
- **Immunization for Tetanus, Diptheria, and Acellular Pertussis (TDAP) is required**. Vaccination must have been obtained in 2008 or later.
- **Screening for Tuberculosis is also required**. Both positive and negative PPD readings **must be recorded in millimeters**.
    - For individuals with a history of **negative TB skin tests**, please do the following 1) provide the results from one TB skin test completed within one year of start date, and 2) provide the results of a TB skin test within 3 months of start date. In lieu of two PPD test results, you may provide one negative QuantiFERON test result within 12 months of start date.
    - For individuals with a **positive TB skin test**, a copy of the **written interpretation of a chest x-ray** taken within 12 months of start date.
- **SUPPORTING DOCUMENTATION OF VACCINATIONS IS NOT REQUIRED BUT MAY BE REQUESTED BY THE OFFICE OF GME.**
- All documents submitted require the name of a Health Care Provider, address, phone number, and licensing information (this must be written legibly on the attached forms).
- **ALL INFORMATION IS CONFIDENTIAL**. It will be entered into a confidential, centralized, HIPAA-compliant database for purposes of reducing risk of exposure to TB, vaccine-preventable diseases, and bloodborne pathogens.

Please return these completed forms to your Program Coordinator.

UNIVERSITY OF CALIFORNIA SAN FRANCISCO
SCHOOL OF MEDICINE, GRADUATE MEDICAL EDUCATION

PRE-PLACEMENT HEALTH STATEMENT FOR NON-MD VISITING TRAINEES

First Name **Last Name** **Date of Birth** **Social Security Number**

MEASLES (rubeola)

1) 2 doses live measles vaccine or 2 doses MMR vaccine **OR** **2) Positive measles titer**

Date: _____/_____/_____
Dose 1: ☐Measles or ☐ MMR ?

Date: _____/_____/_____
Dose 2: ☐ Measles or ☐ MMR ?

Date: _____/_____/_____

MUMPS

1) 2 doses live mumps vaccine or MMR vaccine **OR** **2) Positive mumps titer**

Date: _____/_____/_____
Dose 1: ☐ Mumps or ☐ MMR ?

Date: _____/_____/_____
Dose 2: ☐ Mumps or ☐ MMR ?

Date: _____/_____/_____

RUBELLA (German measles)

1) 1 dose live rubella vaccine or MMR vaccine **OR** **2) Positive rubella titer**

Date: _____/_____/_____
Dose 1: ☐ Rubella or ☐ MMR ?

Date: _____/_____/_____

VARICELLA (chicken pox)

1) 2 doses live varicella vaccine **OR** **2) Positive varicella titer**

Date: _____/_____/_____
Dose 1

Date: _____/_____/_____
Dose 2

Date: _____/_____/_____

History of disease is not acceptable proof of immunity.

HEPATITIS B – Strongly Recommended.

1) Hepatitis B Surface Ab Titer **OR** **2) 3 doses of HEP B Vaccine**

Date: _____/_____/_____

Positive ____ Negative ____

Date: _____/_____/_____
Dose 1

Date: _____/_____/_____
Dose 2

Date: ____/_____/_____
Dose 3

OR **3) PREVIOUS INFECTION – Must provide core antibody & surface antigen titers.**

Results:

Date: _____/_____/_____ Pos.___ Neg.___
Hep B core Ab titer

Date: _____/_____/_____ Pos.___ Neg.___
Hep B surface antigen

OR 4) ☐ **Vaccine contraindicated for medical reasons** (must complete declination form)

TDAP (Tetanus, Diptheria, and Acellular Pertussis) 1 dose of vaccine

Date: ____/____/_____
(must be 2008 or later)

FOR PROVIDER: I attest that all dates and immunizations listed above are correct and accurate. **I have examined the above named physician within the past 30 days and certify that he/she is in satisfactory physical health** and is free from symptoms indicating the presence of infectious disease (if applicable, a list of exceptions is attached).

Name _____ Signature _____

Title _____ License # _____

Phone _____ Fax _____

Address _____

Trainee should be prepared to provide supporting documentation if requested.

UNIVERSITY OF CALIFORNIA SAN FRANCISCO
SCHOOL OF MEDICINE, GRADUATE MEDICAL EDUCATION

NON- MD VISITING TRAINEES PPD REPORTING FORM

First Name	Last Name	Date of Birth	Social Security Number

SIGN AND SYMPTOM REVIEW

Please fill out the following questions and have your provider fill out the questions related to PPD history below.

Have you ever had any of the following symptoms for more than three weeks at a time? *(Please check **ALL** appropriate boxes)*

Excessive sweating at night	☐ Yes	☐ No	Coughing up blood	☐ Yes	☐ No
Excessive weight loss	☐ Yes	☐ No	Hoarseness	☐ Yes	☐ No
Persistent coughing	☐ Yes	☐ No	Persistent fever	☐ Yes	☐ No
Excessive fatigue	☐ Yes	☐ No			

If you have any of the above symptoms, you should meet with your provider to determine whether a chest x-ray is indicated. If a chest x-ray is indicated, please attach documentation.

Have you ever received BCG vaccine? ☐ Yes ☐ No ☐ Don't Know

Year of most recent BCG _____ Country _____

PPD NEGATIVE HISTORY In lieu of 2 PPDs, 1 negative QuantiFERON test result within 12 months of start date may be submitted.

Recent TB Skin Test *(within 3 months of start date)*	**Prior TB Skin Test** *(within one year of start date)*
Date Applied: / /	Date Applied: / /
Date Read: / /	Date Read: / /
mm Reading: mm	mm Reading: mm

PPD POSITIVE HISTORY (induration of 10mm or more)

Year of TB skin test conversion _____ **mm Reading** _____

CHEST X-RAY REQUIRED: Please attach copy of chest x-ray interpretation. X-ray must be done within 12 months of start date.	**INH / Other Therapy:**
Date of last Chest X-Ray: / /	**INH Therapy Taken**: ☐ Yes ☐ No Length of Treatment: _____ months
X-Ray Results: ☐ Normal ☐ Abnormal	**Other Therapy**: ☐ Yes ☐ No Length of Treatment: _____ months

FOR PROVIDER: I attest that all dates and information listed above are correct and accurate.

Name _____ Signature _____

Title _____ License # _____

Phone _____ Fax _____

Address _____

UCSF COMMUNICABLE DISEASE PREVENTION PROGRAM
Employee Fact Sheet

OCCUPATIONAL EXPOSURE TO HEPATITIS B VIRUS (HBV)

HEPATITIS B: Hepatitis B is a viral infection of the liver caused by Hepatitis B virus (HBV). About 1.25 million people in the U.S. have chronic Hepatitis B virus infection. Each year approximately 300,000 new infections are reported to the Center for Disease Control. Most people who become infected with Hepatitis B recover completely, but 5 to I0% will become chronic carriers of the virus. Although many chronic carriers do not have symptoms of the disease, they are capable of transmitting the virus to other persons, primarily through blood exposures or sexual contact. Each year 4,000 to 5,000 persons die from chronic Hepatitis B.

OCCUPATIONAL EXPOSURE: In the hospital and university setting, health care workers with direct patient contact, laboratory workers and researchers with blood or body fluid contact are at increased risk for acquiring the Hepatitis B virus. An unvaccinated individual who receives an accidental blood or body fluid exposure from an infected source has a 40% chance of becoming infected with Hepatitis B. Each year in the U.S., more than 9,000 health care workers contract Hepatitis B, and of those, 300 will die of liver-related disease.

VACCINATION: Becoming infected with Hepatitis B is preventable. The Hepatitis B vaccine, a synthetic vaccine made from a yeast base, is currently being offered to health care workers and other exposed staff at UCSF at no cost to the employee. Full immunization requires completion of a series of three vaccinations given over a six-month period. Eighty to 90% of healthy people who receive the vaccine develop antibodies which protect them from getting Hepatitis B. There is no evidence that the vaccine has ever caused Hepatitis B. At this time, no one knows how long the immunity produced by the vaccine will last and the need for additional vaccinations has not been determined. Health care workers who are immunocompromised or on dialysis might require increased doses of vaccine in order to convert to positive antibodies. The incidence of side effects is very low. A few people experience tenderness and redness at the injection site. A low grade fever may occur. Rash, nausea, joint pain and mild fatigue have also been reported.

TREATMENT OF EXPOSURE: If the individual has received the Hepatitis B vaccine and has documented antibodies to HBV, no further treatment is necessary at the time of exposure. However, someone who is not protected by the vaccine and does not have antibodies to HBV, needs to receive HBIG (Hepatitis B Immunoglobulin) as soon as possible after the exposure. These persons are also encouraged to receive the Hepatitis B vaccine at this time.

UCSF has a **24-hour EXPOSURE HOTLINE** for anyone who has a blood or body fluid exposure. Anyone with an exposure at Parnassus should call **415-353-7842 (STIC)**. If you have any questions about Hepatitis B or the Hepatitis B vaccine, call Employee and Occupational Health Services at (415) 885-7580.

Please sign and return this form *IF YOU HAVE NOT RECEIVED THE HEPATITIS B VACCINE AND CHOOSE NOT TO BE VACCINATED*.

HEPATITIS B VACCINATION DECLINATION

I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with Hepatitis B vaccine at no charge to myself. However, I decline Hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination series at no charge to me.

Signature _____ Date _____

Full Name _____ Social Security Number _____

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO CONFIDENTIALITY OF PATIENT, EMPLOYEE AND UNIVERSITY BUSINESS INFORMATION AGREEMENT

STATEMENT OF PRIVACY LAWS AND UNIVERSITY POLICY

It is the legal and ethical responsibility of all UCSF faculty, staff, house staff, students, trainees, volunteers, and contractors to use, protect, and preserve personal and confidential patient, employee, student, and University business information, including medical information for clinical or research purposes (referred to here collectively as "Confidential Information"), in accordance with state and federal laws and University policy.

Laws controlling the privacy of, access to, and maintenance of Confidential Information include, but are not limited to, the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Health Information Technology for Economic and Clinical Health Act (HITECH), the HIPAA Final Omnibus Rule, the California Information Practices Act (IPA), the California Confidentiality of Medical Information Act (CMIA), and the Lanterman- Petris-Short Act (LPS), and the Family Educational Rights and Privacy Act of 1974 (FERPA). These and other laws apply whether the information is held in electronic or any other format, and whether the information is used or disclosed orally, in writing, or electronically.

University policies that control the way Confidential Information may be used include, but are not limited to, the following: UCSF Medical Center Policies 05.01.04 and 05.02.01, LPPI Policies, UCSF Policy 650- 16 Minimum Security Standards, UCSF Policy 130-00 Disclosure of Information from Student Records, UC Standards of Ethical Conduct--University Resources, UC Personnel Policies PPSM 80 and APM 160, applicable union agreement provisions, and UC Business, UC Business and Finance Bulletin IS-3 Electronic Information Security, and Finance Bulletin RMP 8.

"Confidential Information" includes information that identifies or describes an individual, the unauthorized use, access or disclosure of which (a) is prohibited by federal or state laws, or (b) would otherwise constitute an unreasonable invasion of personal privacy. Examples of confidential employee and University business information include home address, telephone number, medical information, date of birth, citizenship, social security number, spouse/partner/relative names, income tax withholding data, performance evaluations, proprietary/trade secret information, and peer review/risk management information and activities. Most information in student records is confidential.

"Medical Information" includes the following no matter where it is stored and no matter the format: medical and psychiatric records, photos, videotapes, diagnostic and therapeutic reports, x-rays, scans, laboratory and pathology samples, patient business records (such as bills for service or insurance information), visual observation of patients receiving medical care or accessing services, and verbal information provided by or about a patient. Medical Information, including Protected Health Information (PHI), is maintained to serve the patient, health care providers, health care research, and to conform to regulatory requirements.

Unauthorized use, disclosure, viewing of, or access to Confidential Information in violation of state and/or federal laws may result in personal fines, civil liability, licensure sanctions and/or criminal penalties, in addition to University disciplinary actions.

University Privacy Policy and Acknowledgement of Responsibility

I understand and acknowledge that:

- It is my legal and ethical responsibility as an authorized user to preserve and protect the privacy, confidentiality and security of all Confidential Information relating to UCSF, its patients, students, activities and affiliates, in accordance with applicable laws and University policy.
- I will access, use and disclose Confidential Information only in the performance of my University duties, when required or permitted by law, and disclose information only to persons who have the right to receive that information. When using or disclosing Confidential Information, I will use or disclose only the minimum information necessary.

- I will discuss Confidential Information for University-related purposes only. I will not knowingly discuss any Confidential Information within hearing distance of other persons who do not have the right to receive the information. I will protect Confidential Information which is disclosed to me in the course of my relationship with UCSF.
- Special legal protections apply to and require specific authorization for release of mental health records, drug abuse records, and any and all references to HIV testing, such as clinical tests, laboratory or others used to identify HIV, a component of HIV, or antibodies or antigens to HIV. I will obtain such authorization for release when appropriate.
- My access to all University electronic information systems is subject to monitoring and audits in accordance with University policy.
- My User ID(s) constitutes my signature and I will be responsible for all entries made under my User ID(s). I agree to always log off of shared workstations.
- It is my responsibility to follow safe computing guidelines.
    - I will use **encrypted** computing devices (whether personal or UCSF-owned), such as desktop computers, laptop computers, tablets, mobile phones, flash drives, and external storage, **for any UCSF work purpose** which involves the use, exchange, or review of Protected Health Information or Personally Identifiable Information, including but not limited to, clinical care, quality reviews, research, educational presentations/conferences, and financial or personnel-related records. Encryption must be a UCSF-approved solution.
    - **I may be personally responsible** for any breach of confidentiality resulting from an unauthorized access to data on an unencrypted device due to theft, loss or any other compromise. I will contact the UCSF IT Service Desk at (415) 514-4100 for questions about encrypting my computing device.
    - I will not share my **Login or User ID and password** with any other person. If I believe someone else has used my Login or User ID and password, I will immediately report the use to the UCSF IT Service Desk at (415) 514-4100 and request a new password.
- Under state and federal laws and regulations governing a patient's right to privacy, unlawful or unauthorized access to or use or disclosure of patients' Confidential Information may subject me to civil fines for which **I may be personally responsible**, as well as criminal sanctions. Under University policy, I may also be subject to disciplinary action up to and including immediate termination from my employment/professional relationship with UCSF.

By signing below:

- **I attest that I have encrypted or will encrypt all of my personal computing devices before using them for any UCSF work purpose, unless I have an encryption exception approved by the UCSF Information Security Officer. I will not use an unencrypted computing device for UCSF work purposes without an approved exception.**
- **I attest I have read, understand, and acknowledge all of the above STATEMENTS OF UNIVERSITY PRIVACY POLICY and the ACKNOWLEDGEMENT OF RESPONSIBILITY.**

_____	_____
Signature	Date
_____	_____
Print Name	UCSF Department
_____	_____
UCSF Employee Number	Signature of Manager or UCSF Representative
❑ Non-UCSF Employee	_____
	Print Manager or UCSF Representative Name

PATENT ACKNOWLEDGEMENT FORM

This acknowledgment is made by me to The Regents of the University of California, a corporation, hereinafter called "University," in part consideration of my employment, and of wages and/or salary to be paid to me during any period of my employment, by University, and/or my utilization of University research facilities and/or my receipt of gift, grant, or contract research funds through the University.

By execution of this acknowledgment, I understand that I am not waiving any rights to a percentage of royalty payments received by University, as set forth in the University of California Patent Policy, hereinafter called "Policy."

I also understand and acknowledge that the University has the right to change the Policy from time to time, including the percentage of net royalties paid to inventors, and that the policy in effect at the time an invention is disclosed shall govern the University's disposition of royalties, if any, from that invention. Further, I acknowledge that the percentage of net royalties paid to inventors is derived only from consideration in the form of money or equity received under: 1) a license or bailment agreement for licensed rights, or 2) an option or letter agreement leading to a license or bailment agreement. I also acknowledge that the percentage of net royalties paid to inventors is not derived from research funds or from any other consideration of any kind received by the University. The Policy on Accepting Equity When Licensing University Technology governs the treatment of equity received in consideration for a license.

I acknowledge my obligation to assign, and do hereby assign, inventions and patents that I conceive or develop within the course and scope of my University employment while employed by University or during the course of my utilization of any University research facilities or through any connection with my use of gift, grant, or contract research funds received through the University. I further acknowledge my obligation to promptly report and fully disclose the conception and/or reduction to practice of potentially patentable inventions to the University authorized licensing office. Such inventions shall be examined by University to determine rights and equities therein in accordance with the Policy. I shall promptly furnish University with complete information with respect to each.

In the event any such invention shall be deemed by University to be patentable or protectable by an analogous property right, and University desires, pursuant to determination by University as to its rights and equities therein, to seek patent or analogous protection thereon, I shall execute any documents and do all things necessary, at University's expense, to assign to University all rights, title, and interest therein and to assist University in securing patent or analogous protection thereon. The scope of this provision is limited by Calif. Labor Code Sec. 2870, to which notice is given below. In the event I protest the University's determination regarding any rights or interest in an invention, I acknowledge my obligation: (a) to proceed with any University requested assignment or assistance; (b) to give University notice of that protest no later than the execution date of any of the above-described documents or assignment; and (c) to reimburse University for all expenses and costs it encounters in its

patent application attempts, if any such protest is subsequently sustained or agreed to.

I acknowledge that I am bound to do all things necessary to enable University to perform its obligations to grantors of funds for research or contracting agencies as said obligations have been undertaken by University.

University may relinquish to me all or a part of its right to any such invention, if, in its judgment, the criteria set forth in the Policy have been met.

I acknowledge that I am bound during any periods of employment by University or for any period during which I conceive or develop any invention during the course of my utilization of any University research facilities, or any gift, grant, or contract research funds received through the University.

In signing this acknowledgment,I understand that the law, of which notification is given below, applies to me, and that I am still required to disclose all my inventions to the University.

NOTICE

This acknowledgment does not apply to an invention which qualifies under the provision of Calif. Labor Code Sec.2870 which provides that (a) Any provision in an employment agreement which provides that an employee shall assign, or offer to assign, any of his or her rights in an invention to his or her employer shall not apply to an invention that the employee developed entirely on his or her own time without using the employer's equipment, supplies, facilities, or trade secret information except for those inventions that either: (1) Relate at the time of conception or reduction to practice of the invention to the employer's business, or actual or demonstrably anticipated research or development of the employer; or (2) Result from any work performed by the employee for the employer. (b) To the extent a provision in an employment agreement purports to require an employee to assign an invention otherwise excluded from being required to be assigned under subdivision (a), the provision is against the public policy of this state and is unenforceable.

In any suit or action arising under this law, the burden of proof shall be on the individual claiming the benefits of its provisions.

Employee/Guest Name (Please print) _____

Employee/Guest Signature: _____

Date Witness Signature: _____

Date: _____

Participant's name: _____
Please Print

UNIVERSITY OF CALIFORNIA, San Francisco

Name of Class or Activity

Waiver of Liability, Assumption of Risk, and Indemnity Agreement

Waiver: In consideration of being permitted to participate in any way in

Description of Class or Activity including date(s)

hereinafter called "The Activity", I, for myself, my heirs, personal representatives or assigns, **do hereby release, waive, discharge, and covenant not to sue** The Regents of the University of California, its officers, employees, and agents from liability **from any and all claims including the negligence of The Regents of the University of California, its officers, employees and agents,** resulting in personal injury, accidents or illnesses (including death), and property loss arising from, but not limited to, participation in The Activity.

_____ _____

Signature of Parent/Guardian of Minor Date Signature of Participant Date

Assumption of Risks: Participation in The Activity carries with it certain inherent risks that cannot be eliminated regardless of the care taken to avoid injuries. The specific risks vary from one activity to another, but the risks range from 1) minor injuries such as scratches, bruises, and sprains 2) major injuries such as eye injury or loss of sight, joint or back injuries, heart attacks, and concussions to 3) catastrophic injuries including paralysis and death.

I have read the previous paragraphs and I know, understand, and appreciate these and other risks that are inherent in The Activity. I hereby **assert that my participation is voluntary and that I knowingly assume all such risks.**

Indemnification and Hold Harmless: I also agree to INDEMNIFY AND HOLD The Regents of the University of California HARMLESS from any and all claims, actions, suits, procedures, costs, expenses, damages and liabilities, including attorney's fees brought as a result of my involvement in The Activity and to reimburse them for any such expenses incurred.

Severability: The undersigned further expressly agrees that the foregoing waiver and assumption of risks agreement is intended to be as broad and inclusive as is permitted by the law of the State of California and that if any portion thereof is held invalid, it is agreed that the balance shall, notwithstanding, continue in full legal force and effect.

Acknowledgment of Understanding: I have read this waiver of liability, assumption of risk, and indemnity agreement, fully understand its terms, and **understand that I am giving up substantial rights, including my right to sue**. I acknowledge that I am signing the agreement freely and voluntarily, and **intend by my signature to be a complete and unconditional release of all liability** to the greatest extent allowed by law.

_____ _____

Signature of Parent/Guardian of Minor Date Signature of Participant Date

Participant's Age (if minor) _____