**APPLICATION FOR APPOINTMENT**
**RESEARCH ASSOCIATE**

Enclosed is the application for appointment to the position of Research Associate.

**You must respond to all questions.** Your application will be considered incomplete if you fail to respond to any questions. If a question does not apply to you, please respond by stating "not applicable".

The following information/materials must be included with the completed application. We recommend you use this as a checklist to assure compliance.

- ❑ **Signed** Attestation page from "Kaleida Health Research Associate Orientation Manual." (Orientation Manual is a separate document, not included in this packet.)
- ❑ Completed Application for Appointment Research Associates.
- ❑ **Signed** General Indemnification Form ("Certifications, Authorizations and Waivers of Liability").
- ❑ Completed Scope of Project Form, **signed by PI or Supervisor** (attach IRB approval).
- ❑ Completed and **signed** Core Competencies CITI Program and attach proof of completion.
- ❑ ***If applicable,*** **signed** UB Med Student Research Associate Attestation Letter. For med students only. **(If this letter is signed, the next two items are not needed.)**
- ❑ Current completed and **signed** Research Associate Proof of Immunizations and Physical Exam with PPD testing and flu shot completed within the previous 12 months.
- ❑ Check in amount of $50.00 made payable to "Kaleida Health Office of Research and Sponsored Projects".

**PLEASE NOTE: Your scope of project must fall within the scope of privileges held by your Supervising/collaborating physician. Any questions should be directed to the Office of Research and Sponsored Projects to Danni Zhang, Clinical Regulatory Administrator, at DXZhang@KaleidaHealth.org.**

**PLEASE RETURN ALL DOCUMENTS TO:**

Danni Zhang
Clinical Regulatory Administrator
*dxzhang@kaleidahealth.org*

Kaleida Health

**APPLICATION FOR APPOINTMENT RESEARCH ASSOCIATES**

| **IDENTIFYING INFORMATION** | | | |
|---|---|---|---|
| **Name:** | | **Service:** | |
| | **US Citizen?** ☐Yes ☐No (if no, see next question) | **Valid VISA** ☐Yes ☐No ☐N/A | |
| **Address:** | **City:** | **State:** | **Zip:** |
| **Email:** | | | |
| *(Email address must be secured affiliate email address, if not available a KaleidaHealth.org email address may be requested)* | | | |
| **Phone:** | **Cell:** | | |
| **Affiliation:** ☐University of Buffalo ☐Other Educational Institution: | | ☐Other:_____ | |

**DISCLOSURES**

**1. Have any of the following been denied, revoked, suspended, sanctioned, reduced, limited, monitored, placed on probation, not renewed, or voluntarily relinquished to avoid possible disciplinary action in any jurisdiction?**

a. medical, dental or other professional license ☐Yes ☐No
b. controlled substance registration (DEA) ☐Yes ☐No
c. academic appointment ☐Yes ☐No
d. membership in or affiliation with any health care facility staff ☐Yes ☐No
e. clinical privileges at any health care facility ☐Yes ☐No
f. prerogatives or rights at any health care facility ☐Yes ☐No
g. professional society membership or fellowship ☐Yes ☐No
h. board certification ☐Yes ☐No
i. professional liability insurance ☐Yes ☐No
j. participation in any private, Federal or state insurance program (eg. Medicare, Medicaid) ☐Yes ☐No

**2. To the best of your knowledge:**

a. Have you ever been charged with professional misconduct or received an administrative warning by any state agency or professional association? ☐Yes ☐No
b. Are you the subject of any current investigation by any state agency or professional body? ☐Yes ☐No
c. Have there ever been any findings or have you ever been found to be in violation of Patient Rights? ☐Yes ☐No
d. Have any judgments or settlements been rendered against you in a professional liability case? ☐Yes ☐No
e. Have you received notice of malpractice actions which are pending? ☐Yes ☐No
f. Do you have any physical or mental disabilities which may interfere with your ability to complete the essential functions of your disciplinary specialty?o you have any physical or mental disabilities which may interfere with your ability to complete the essential functions of your disciplinary specialty? ☐Yes ☐No

**3. If the answer is *YES* to any of the above questions, please explain below**

***I understand that it is my responsibility to advise Kaleida Health in writing immediately of any new, different, or additional information responsive to any of the above questions.***

## CERTIFICATIONS, AUTHORIZATIONS AND WAIVERS OF LIABILITY

I fully understand that any misstatements in, or omissions from, this application or the supporting documentation submitted herewith, constitutes cause for denial of my request or cause for summary dismissal. All information submitted by me in connection with this application is true and complete to the best of my knowledge and belief and no pertinent information has been omitted.

In making this application, I acknowledge that I am familiar with the principles and standards of the Det Norske Veritas (DNV), the Guidelines for Good Clinical Practice, and Ethical Principles and Guidelines for the Protection of Human Subjects of Research contained in the Belmont Report and the Declaration of Helsinki. I agree to be bound by the principles thereof, and I further agree to abide by such Hospital(s) policies as may be from time to time amended and enacted.

I hereby signify my willingness to appear for a personal interview in regard to my application, authorize the Hospital(s) representatives to consult with administrators and members of other hospitals or institutions with which I may have been associated and with others, including past and present malpractice insurance carriers, who may have information bearing on my professional competence, character and ethical qualifications. I hereby further consent to the inspection by Kaleida Health and its representatives of all records and documents, including medical records from other hospitals that may be made material to an evaluation of my professional qualifications and competence to carry out the privileges requested as well as my moral and ethical qualifications for the position as Research Associate. I hereby release from liability Kaleida Health and its representatives for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications. I hereby release from any liability, any and all individuals and organizations who provide information to Kaleida Health in good faith and without malice concerning my professional competence, ethics, character and other qualifications and I hereby consent to the release of such information.

I authorize Kaleida Health to conduct a criminal record background check.

I authorize Kaleida Health to share the information I provide in this application for Research Associate privileges to Erie County Medical Center Corporation in order to expedite its research associate application process, if applicable.

I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics, and other qualifications and for resolving any questions or doubts about such qualifications. I have been advised of, and hereby acknowledge, my obligation to advise Kaleida Health in writing immediately of any new, different or additional information responsive to any of the questions or items requested in or in connection with this application which, at any time it comes to my attention or is made known to me.

_____ _____

**DATE** **SIGNATURE OF APPLICANT**

| **SCOPE OF PROJECT**<br>*(PLEASE COMPLETE ONE PAGE FOR EACH RESEARCH PROJECT)* | |
|---|---|
| **APPLICANT'S NAME:** | |
| **TOPIC TO BE RESEARCHED:** | |
| **Principal Investigator (PI) or Supervising member of the Kaleida Health Medical Dental Staff**: | |
| **PROJECT INFORMATION** | |
| **Start Date:** | **Completion Date:**<br>(You must notify Kaleida in writing at completion of the study) |
| **Is Project IRB-Approved?** ☐ Yes (Attach IRB Letter). **IRB Study #:**<br>☐ Pending; submitted to [IRB name] on [Date]<br>☐ Will submit to [IRB name] on [Date] | |
| **Age of Patient Population:** ☐Pediatric (<18y) ☐Adult (18y – 74y) ☐Geriatric (>75y) ☐Other, please specify | |
| **How will potential research subjects be identified?**<br><br>**Who will approach the subjects regarding participation?** | |
| **Will the research study require Kaleida to disclose patients' protected health information to the researcher**?<br>☐Yes ☐No | |
| **What form of authorization has been obtained for release of protected health information?**<br><br>(If being used, attach sample of Signed Authorization from each patient or the approved copy of the IRB HIPAA Waiver of Authorization) | |
| **What specific research functions will the applicant be assisting with?** | |

**RESEARCH SPONSOR CERTIFICATION**

**I _____(*print name of PI or Supervisor*) acknowledge that a Research Associate MAY NOT PROVIDE PATIENT CARE and I attest that this Research Associate will be supervised by a member of the Kaleida Health Medical Dental Staff. The Research Associate's tasks, including those involving patient contact and/or patient-related activities, are limited to those specifically defined and approved within this Scope of Project.**

**I personally attest to the applicant's competence with regard to the activities listed above and understand that following submission and review of this request, additional documentation may be required.**

| _____ | _____ | _____ |
|---|---|---|
| **DATE** | **Print Name of PI or Supervisor** | **Signature of PI or Supervisor** |

## Core Competencies

1. All Research Associates conducting research with human subjects must earn their Continuing Research Education Credit (CREC) certificate by completing the initial core training in the protection of human subjects through the Collaborative Institutional Training Initiative (CITI Program) prior to beginning research activities. These free and nationally recognized training courses can be found online at: https://about.citiprogram.org/en/homepage/. When registering, enter "SUNY - Buffalo (University at Buffalo)" as your Organization Affiliation.

   **Please attach proof of completion certificates for the following CITI programs:**

   - ☐ Biomedical Research Faculty, Staff and Students OR Social and Behavioral Research Faculty, Staff and Students (as appropriate)
   - ☐ Conflict of Interests (COI)
   - ☐ Good Clinical Practice (GCP)

2. All Research Associates conducting research at Kaleida Health must read and understand the following internal policies before beginning their research (included in Orientation Manual):

   - ☐ ORSP.6 - Use and Disclosure of Protected Health Information for Research Purposes
   - ☐ ORSP.4 - Research Record Retention
   - ☐ IC.12 - Standard & Transmission-Based Precautions
   - ☐ IAC.19 - Code of Conduct and Business Ethics
   - ☐ ORSP.11 - Human Subject Protection
   - ☐ IAC.31 - Language Assistance Plan
   - ☐ Corporate Compliance and HIPAA
   - ☐ Language Assistance Services
   - ☐ Requests for Support of Research Activities

I _____ (applicant's name) hereby certify that I have listened to and/or read and understand the Kaleida Health Core Competencies listed above. I understand that I am required to comply with all Kaleida Health policies, rules and regulations. I understand that if this attestation is found to be false or untrue, the provision of any false or misleading information on this form may subject me to disciplinary action up to and including dismissal or termination of my privileges.

I agree to conduct myself in a professional manner at all times while on the Kaleida Health campus and will support the hospital's mission and vision of providing excellence in health care.

_____
Name (Please Print)

_____ _____
Signature Date

University at Buffalo
The State University of New York

Date:_____

Kaleida Health - Office of Research and Sponsored Projects
Deonna Coleman ichael eecher, D
Director Clinical StudiesChief edical Officer, uffalo eneral edical Center, ates ascular Institute
Kaleida Health
726 Exchange Street, Buffalo, NY 142100

The purpose of this letter is to confirm that _____ (Student name) is enrolled as a medical student at the State University of New York University at Buffalo Jacobs School of Medicine and Biomedical Sciences ("UB") as of _____ (date) and meets Kaleida Health's requirements for access to its electronic medical records containing protected health information (as that term is defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and its implementing regulations) for research purposes.

Any UB student who would like access to a Kaleida Health's electronic medical record containing protected health information for research purposes must meet the following requirements:

- If a non-US Citizen, s/he has the necessary documentation to study in the United States.
- S/he has attended UB orientation within the last 12 months pertaining to the privacy of patient's protected health information, including HIPAA requirements.
- Upon admission to UB, s/he has had a criminal background check run against him/her which covers that period of time prior to entry into medical school.
- As required for research involving patient interaction, s/he is covered by UB's Professional and General Liability insurance coverage with limits of
    - At least one million dollars ($1,000,000) per occurrence and
    - At least three million dollars ($3,000,000) annual aggregate
- S/he complies with the New York State Department of Health, Bureau of Immunization requirements for vaccinations:
    - Receipt of 2 documented doses of MMR vaccine, given on or after the first birthday and separated by at least 28 days is proof of immunity to measles, mumps, and rubella.
    - Documentation of immunity to varicella:
        - Documentation of 2 doses of varicella vaccine given at least 28 days apart, or
        - History of varicella disease (chickenpox) or herpes zoster (shingles) or
        - Laboratory evidence of immunity or conformation of disease.
    - Annual negative tuberculin (TB, TST or QFT) screen and/or negative CXR
        - If history of having TB or a positive TB screen, must show completed treatment or a negative chest X-ray within the past two years.
    - TDaP vaccine/booster within past ten (10) years (tetanus, diphtheria & pertussis).
    - Full Hepatitis B vaccine series and/or immunity to Hepatitis B.
    - Seasonal influenza (flu) vaccination received.

I certify that:

- the aforementioned student satisfies the foregoing requirements,
- the student will continue to satisfy all of the foregoing requirements through the end of his/her clinical rotation at Kaleida Health, and
- UB maintains records documenting compliance with all requirements contained in this letter and will share the records with Kaleida Health within three business days of a request to do so.

I understand and agree that (a) all UB students requiring access to Kaleida Health's electronic medical records containing protected health information for research purposes must complete an abbreviated credentialing application for Research Associates and (b) Kaleida Health's Office of Research and Sponsored Projects must give its approval before a UB student will be granted access to any of Kaleida Health's electronic medical records containing protected health information for research purposes.

Kind Regards,

| | | |
|---|---|---|
| **David A. Milling, MD, FACP** | or, **Nicholas J. Silvestri, MD, FAAN** | or, **Samantha Bordonaro, MD, FACEP** |
| Senior Associate Dean for Student and Academic Affairs | Associate Dean for Student and Academic Affairs | Assistant Dean for Student and Academic Affairs |
| Jacobs School of Medicine and Biomedical Sciences, University at Buffalo | Jacobs School of Medicine and Biomedical Sciences, University at Buffalo | Jacobs School of Medicine and Biomedical Sciences, University at Buffalo |

**NOTE: If UB Med Student Research Associate Attestation Letter is signed, this form is not required.**

Kaleida Health

## Research Associate Proof of Immunizations and Physical Exam

ew York State Department of Health **requires** the following to medically clear you to work at a hospital: **Physical, 2 step PPD**, proof of immunization/immunity to **Rubella, Rubeola, Mumps and Varicella**.

| | | | | | |
|---|---|---|---|---|---|
| Last Name: | | | First Name: | | |
| Sex: | ☐ Male ☐ Female | DOB: | | Phone: | |
| Address: | | | | | |

| **Immunization History (Vaccines)** *Attach Immunization Record* | | |
|---|---|---|
| **Vaccine** | **Date** | |
| **Flu/Influenza** (1 dose annually) | | |
| **Varicella Vaccine (chicken pox)** (or positive titer) | #1: | #2: |
| **MMR** (Measles, Mumps, Rubella) | #1: | #2: |
| **OR** | | |
| **Measles** (or positive titer) | #1: | #2: |
| **Mumps** (or positive titer) | #1: | #2: |
| **Rubella** (or positive titer) | #1: | |

**New Associate:** **Must have two (2) separate PPD/TB Skin Tests administered within the past 12 months. Second test to be done 1-3 weeks after initial test. Complete the following section.**

**Reappointment:** **No PPD/TB Skin Test required. Please complete attached Tuberculosis Annual Risk Assessment Screening Tool and return.**

| **(New Research Associate only)** | | |
|---|---|---|
| **PPD #1 Date Placed:** | **Date Read:** | **Results in mm:** |
| **PPD #2 Date Placed:** | **Date Read:** | **Results in mm:** |
| **If known history of positive PPD, provide date of conversion and last chest x-ray:** | | |
| **Positive PPD Date:** | **Results in mm:** | |
| **Date of X-Ray:** | ☐ **Normal Chest X-Ray** | ☐ **Abnormal Chest X-Ray** |
| ☐ Asymptomatic-denies all symptoms | | |
| ☐ Symptomatic-fatigue, Anorexia, Weight loss, Low grade fever, Productive cough *(circle any that pertain)* | | |

The above individual has been evaluated in the past 12 months. The results of the evaluation is of sufficient scope to ensure the above named person is free from health impairment which is of potential risk to the patient or which might interfere with the performance of his/her duties, including habituation or addiction to depressants, stimulants, narcotics, alcohol, other drugs or substances which may alter the individual behavior.

***The office that is completing this form will be responsible for maintaining updated medical records for the duration of participant's and/or faculty's interactions within Kaleida Health facilities and provide appropriate supporting documentation upon request.***

Healthcare Provider or Facility: _____ Phone: _____

Healthcare Provider or Facility Signature: _____ Date: _____

**Provider/Facility Stamp with Address and Telephone Number:**

Kaleida Health

# DECLINATION OF INFLUENZA VACCINATION FOR HEALTH CARE PERSONNEL

I have been advised that I should receive the influenza vaccine to protect myself and the patients I serve. I have read the Centers for Disease Control and Prevention's (CDC) Vaccine Information Statement explaining the vaccine and the disease it prevents. I have had the opportunity to discuss the statement and have my questions answered by a healthcare provider. I am aware of the following facts:

- Influenza is a serious respiratory disease that kills thousands in the United States each year.
- Influenza vaccination is recommended for me and all other healthcare personnel to protect this facility's patients from influenza, its complications and death.
- If I contract influenza, I can shed the virus for 24 hours before influenza symptoms appear. My shedding the virus can spread influenza to patients and coworkers in this facility.
- If I become infected with influenza, I can spread severe illness to others even when my symptoms are mild or non-existent.
- I understand that the strains of virus that cause influenza infection change almost every year and even if they don't, my immunity declines over time. This is why vaccination against influenza is recommended each year.
- I understand that I cannot get influenza from the influenza vaccine.
- The consequences of my refusing to be vaccinated could have life threatening consequences to my health, and the health of those with whom I have contact, including all patients in this healthcare facility, coworkers, my family and my community.
- **Because I have refused vaccination against influenza, regardless of the reason, I will be required to wear a surgical mask in areas where patients or residents are typically present during the period of time that influenza is designated "prevalent" by the Commissioner of the NYSDOH.**

I have read the information above regarding the **Seasonal Influenza Vaccine** and:

☐ I have a **medical condition** that might be worsened by the vaccine.

☐ Although I have been informed of the risks and benefits of the vaccine, I **do not wish** to receive it.

**I am aware that I can change my mind at any time and accept an influenza vaccination.**

Employee Name (print) _____ Employee ID# _____

Signature _____ Date _____ Date of Birth _____

**Attach Medical Exemption Form DOH-4482 (10/10) for any medical contraindication**

**Return Completed Declination Form to:**
**Kaleida Corporate Employee Health Department**
**726 Exchange Street, Suite 240**
**Buffalo, NY 14210**
**OR**
**Return via Interdepartmental Mail**