Columbia University Medical Center Addendum/Rider
Guidelines for Administrative Visitors
(Non-Research/Non-Clinical)

Procedures for CUMC Only:

All visitors who have been invited to participate in programs and activities in offices and laboratories at the Medical Center are required to register in their departments and forms are to be forwarded immediately to the CUMC Human Resources Office located at 650 West 168th Street, Black Building, Room 101 prior to their start date. Departments must complete a visitor registration form, clearly stating the purpose for which the visitor is at the Medical Center, the activities in which they will be engaged while at the Medical Center, and the anticipated length of their visit. The form must be signed by the visitor, the sponsor and countersigned by a department approver and any other required signatures as indicated on the form. CUMC Human Resources will review and make the final approval to the form. The department can then obtain a temporary identification card for the visitor from Public Safety once the form has been approved. All Visitors are limited to one year.

Certain visitors at the Medical Center may require medical surveillance and/or will undergo a drug screening test as part of the requirement by Workforce Health & Safety (WH&S) prior to their start date.

Any visitors at the Medical Center, providing service at New York Presbyterian Hospital (NYP) must be compliant with the Joint Commission mandates. Joint Commission mandates any visitors who will have direct contact in NYP through the delivery of treatments, the conduct of evaluations, the enrollment of patients in studies, or the collection of data or specimens must comply.

It is the responsibility of principal investigators/sponsor, faculty physicians or dentists, and/or managers in the department, center or administrative unit to make sure that their visitor complete all the required testing (drug screening/medical surveillance and/or appropriate hospital protocol) and attend the appropriate Environmental Health & Safety and/or Radiation Safety training sessions prior to their start date. It is also their responsibility to make sure that their visitor is aware of basic institutional life safety policies and procedures that are applicable to regular employees.

Departments will be notified via email by WHS that the visitor is cleared to begin. If they are under the age of 18, a current Columbia University student or a visitor providing service for less than 5 days, they will not be subject to the drug screening test.

In the event of accident or emergency, the same procedures used for employees should be used for visitors. The individual should be treated at the WHS located in the Harkiness Pavilion, (or the Emergency Room if WHS is not open). In each case, an Accident Report Form should be completed and sent to Disability Services and a copy must be provided to your Departmental Administrator or Supervisor immediately; Please follow the Workers’ Compensation guideline for the Medical Center at: http://hr.columbia.edu/wac/workplace/workers-comp#medical-center

Accident Report Form: http://hr.columbia.edu/files_humanresources/imce_shared/Forms_Disability_Workers-Comp.pdf

Columbia University reserves the right to withdraw any visitor privileges and remove a volunteer, trainee or observer from all campuses and all affiliated locations without prior notice.

Please Note: Questions relating to this guideline should be directed to CUMC Human Resources. Any inquiries pertaining to safety should be directed to the Office of Environmental Health and Safety.
COLUMBIA UNIVERSITY
Office of Human Resources
Visitor Registration Form

Please Indicate:  □ Research  □ Clinical  □ Administrative (Non Research/Non Clinical)

Name: ________________________________________ Date: ________________________________

Home Address: ________________________________ Dept. Name: ________________________________

_______________________________________________ Work Location: ____________________________

Home Phone No.: ________________________________ Work Phone No.: ____________________________

Affiliation (e.g. school or other entity): ______________________________________________________

Are you currently authorized to work in the United States?   ____Yes _____No

Name(s) and Department(s) of Any Family Members Employed at Columbia University:

__________________________

Emergency Contact: Check One:

Name: __________________ Phone No: __________________

Relationship: __________________ Visitor is 14 to 18 Years of Age

Visitor is over 18 Years of Age

Supervisor Name: __________________ Supervisor Phone No: __________________

Supervisor Title: __________________

Describe the Role and Activities to be Performed in Detail (Please attach Resume to this form):

__________________________________________________________

Estimated Number of Hours per Week: ________________

Project Start Date:  _________Project End Date:  ________ (Not to exceed one year)

Will any of the following Special Indicators be part of the duties of the Visitor?

□ Yes  □ No

If Yes, Please check the applicable boxes and schedule the required Medical Surveillance appointment at http://asp.cpmc.columbia.edu/hrorient/msr/ for your visitor.

- Potential Blood Borne Pathogen Exposure
- Contact with Known Infectious Agents (e.g. Varicella, Polio)
- In Laboratory with exposure to a known carcinogen/mutagen/reproductive toxins/extremely toxic substances _____________________________. (Department/Visitor must consult with EH&S when an OSHA regulated substances is used. Also, check lab safety and Chemical Hygiene Plan).
- Class 3b or 4a Lasers (Required only for specific projects)
- Contact with patient or human subjects in an NYPH (New York Presbyterian Hospital) or ACNC (Ambulatory Care Network) space (protocol includes drug testing if not already conducted as part of the pre-employment requirement).
- Contact with patients or human subjects in CUMC space (non-hospital) (protocol does not include drug testing but it may be part of the pre-employment requirement).
- Medical Clearance to wear a full face/half-face respirator.
- Medical Clearance to wear N-95 Face Mask Respirator due to: *Entering the room of a patient on respiratory isolation. *Administering aerosolized ribavirin to patients with respiratory syncytial virus (RSV). *Performing or assisting at a procedure on a patient with influenza.
- Contact with Animals (Research) - medical clearance requirement must be met.

Animals (Research) additional information visit IACUC website: http://www.cumc.columbia.edu/dept/iacuc/ or contact directly at 212-305-24

Any workplace incidents/exposures please complete an Accident Report Form and take to WHS:
http://www.hr.columbia.edu/hr/forms/workers-comp/pdf-ver.pdf or contact Worker's Compensation directly at 212-851-0645.

*Any CUMC Visitors (volunteers, trainees, and observers) over the age of 18, and who is providing service at New York Presbyterian Hospital (NYP) must be compliant with Joint Commission mandates, and therefore are subject to a pre-employment drug screening test.
PLEASE NOTE: If Roles and Responsibilities change from the above description, please notify your CUMC HR Client Manager and CUMC’s Director of Faculty Affairs or the Associate Provost, as applicable, immediately for reassessment.

Visitor Signature: ___________________________________ Date: ________________

PI/Sponsor Authorization: ___________________________________ Date: ________________

Chair/Director/Dept. Authorization: ___________________________________ Date: ________________

Dean’s Office Authorization: ___________________________________ Date: ________________

Executive Vice President for Arts & Sciences Authorization (including Nevis)
___________________________________ Date: ________________

Associate Provost-Morningside Authorization (Morningside, Lamont and Nevis)
___________________________________ Date: ________________

CU HR Authorization (Morningside, Lamont and Nevis; other non-CUMC)
___________________________________ Date: ________________

Office of Faculty Affairs Authorization (CUMC)
___________________________________ Date: ________________

CUMC HR Authorization: ___________________________________ Date: ________________

PLEASE NOTE: This form is used for research, clinical, and administrative short-term visitors. For administrative short-term visitors, not all signatures may be relevant.

For Department Use Only:

- Drug Screening Confirmation Email received from CUMC Human Resources (If applicable)
- Medical Surveillance Appointment Scheduled (If applicable)
- Background Check completed or in progressed (If applicable)
- HIPAA and Security Training
- EH&S Training (If applicable)

CU/CUMC Human Resources Use Only:

- Drug Screening Verified
- Background Check Verified
- Medical Surveillance Appointment Verified
- Resume Attached and Reviewed
Required for Visitors under 18 years of age

My child, __________________________, has my permission to participate as a visitor in the __________ program at Columbia University under the supervision of ___________. I understand that, depending on the kind of project being conducted, my child may be required to participate in environmental health and safety programs and/or medical surveillance may be required for visitors working in research, clinical and educational programs at the University. PLEASE NOTE: For some Visitors at Columbia University Medical Center, a drug screening may be required under the Joint Commission requirements. To the extent that there is a positive drug screening result, both the minor and the parent will be notified. I understand that there may be risk of injury to my child and I agree that I will not hold the Trustees of Columbia University in the City of New York, and its officers, faculty, students, employees, and agents, responsible for any injury that my child may incur at the University or while traveling to and from the University.

Columbia University is committed to promoting a safe environment for minors who participate in our programs and activities. We have taken a number of important steps to establish safeguards for your child. You can read the University’s policy and access other helpful resources at http://compliance.columbia.edu/minors.html.

My child is covered by the following health care plan:

_________________________                          ________________ ________
Insurance Carrier                              Policy/Membership Number

_________________________                _________________________
Name of Insured                                Name of Employer

_________________________        _________________________
Signature of Parent or Guardian       Date

_________________________        _________________________
Signature of Witness                          Date

Print the full name and address of a person who can be reached between the hours of 9:00 a.m. and 5:00 p.m. in case of emergency.

_________________________        _________________________
Name       Relationship

_________________________        _________________________
Address      Phone Number
Columbia University Medical Center
Confidentiality Agreement

As a faculty member, employee, student, affiliate, visitor or volunteer at Columbia University Medical Center (CUMC) you may have access to what this Agreement refers to as "Confidential Information." The purpose of this Agreement is to help you understand your duty regarding Confidential Information.

"Confidential information" includes information about patients, employees, or students or financial or other business or academic information relating to Columbia University Medical Center. You may learn or have access to confidential information through CUMC=computer systems (which include but are not limited to the clinical, human resources and financial information systems) NewYork-Presbyterian (NYP) Hospital computer systems, through interactions with CUMC students, staff or other faculty, or through your treatment of CUMC patients.

As an individual having access to confidential information, you are required to conduct yourself in strict conformance with applicable laws and CUMC policies governing confidential information. As a condition of your relationship to CUMC, you are required to acknowledge and abide by these duties. A violation of any of these duties will subject you to discipline, which might include, but is not limited to, dismissal of your relationship (faculty appointment, employment, student, consulting, etc.) with CUMC, in addition to legal and/or financial liability.

I understand that I may have access to electronic, printed, or spoken confidential information, which may include, but is not limited to, information relating to:

- Patients - including Protected Heath Information (PHI), records, conversations, patient financial information, etc.;
- Employees - including salaries, employment records, disciplinary actions, etc.;
- Students - including enrollment, grade and disciplinary information;
- Research - including PHI created, collected, or used for research purposes;
- CUMC - including but not limited to financial and statistical records, strategic plans, internal reports, memos, peer review information, communications, proprietary computer programs, source code, proprietary technology, etc.;
- Third party information - including computer programs, client and vendor proprietary information, source code, proprietary technology, etc.;
- PHI and Personal Identifying Information (PII) used in other contexts.

Accordingly, as a condition of, and in consideration of my access to confidential information, I promise that:

1. I will use confidential information only as needed by me to perform my legitimate duties as defined by my relationship (faculty, employment, student, visitor, consulting, etc.) with CUMC.
   - I will not access confidential information which I have no legitimate need to know.
   - I will not in any way divulge copy, release, alter, revise, or destroy any confidential information except as properly authorized within the scope of my relationship with CUMC.
     - I will not misuse or carelessly handle confidential information.
     - I understand that it is my responsibility to assure that confidential information in my possession is maintained in a physically secure environment.

2. I will safeguard and will not disclose to any other person my access code (password) or any other authorization code that allows me access to confidential information. I will be responsible for misuse or wrongful disclosure of confidential information that may arise from sharing access codes with another person and/or for failure appropriately to safeguard my access code or other authorization to access confidential information.
   - I will log off computer systems after use.
   - I will not log on to a system or access confidential information to allow another person access to that information or to use that system.
• I will report any suspicion or knowledge that my access code, authorization, or any confidential information has been misused or disclosed without CUMC authorization.
• I will not download or transfer computer files containing confidential information to any non-NYP/CUMC authorized computer, data storage device, portable device, telephone, or other device capable of storing digitized data.
• I will only print documents containing confidential information in a physically secure environment, will not allow other persons’ access to printed confidential information, will store all printed confidential information in a physically secure environment, and will destroy all printed confidential information when my legitimate need for that information ends in a way that protects the confidentiality of the information.

3. I will follow CUMC policies and procedures regarding the use of any portable devices that may contain confidential information including the use of encryption or other equivalent method of protection.

4. I acknowledge my obligation to report to the CUMC Privacy Officer any practice by another person that violates these obligations or puts CUMC, its personnel, or its patients at risk of a disclosure of confidential information.

5. I will only use my Columbia email account to send and receive message that may include confidential information and will not use email to send confidential information to other parties outside of Columbia/NYP without protection to prevent unauthorized access.

6. If I am involved in research, any research utilizing individually identifiable protected health information will be performed in accordance with federal, state, local and Institutional Review Board policies.

7. If I no longer need confidential information, I will dispose in a way that assures others cannot use or disclose it including following the Information Technology policy for disposal of printed confidential information or electronic equipment that may contain confidential information.

8. I understand that my communication using the Columbia University information network is not private and the content of my communication may be monitored to protect the confidentiality and security of the data.

9. I understand that my obligation under this Agreement will continue after termination of my relationship with CUMC.

10. I understand that I have no right or ownership interest in any confidential information referred to in this Agreement. CUMC may at any time revoke my access code, or access to confidential information. At all times during my relationship, I will act in the best interests of CUMC.

_______________________________     _________________________
Name (print)       Date

_______________________________     _________________________
Name (sign)        Department

A copy of this Agreement should be kept in the Department