University Medical Center
New Orleans
LCMC Health

CLINICAL RESEARCH CONTACT FORM

First Name:___________________ **Middle Name:** ___________________ **Last Name:**_____________________

Date of Birth: _____/_____/__________

Personal Email Address:____

Mobile Phone #: ____

Name of Organization: ____

Department Name: ____

Department/Section: ___________________________ **Section Head Name:** ___________________________

Department/Section Phone #: ____

Role/Title: _____________________________________ ☐ Faculty Member ☐ Staff ☐ Medical student/student

Work/School Email Address: ____

By signing this page, I agree to update the UMCNO Office of Research of any changes to the information in this credentialing application.

Research Affiliate Signature **Date**

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RESEARCH AFFILIATE INITIAL REQUIREMENTS CHECKLIST

Name: ____ **Research Role:** ________________________

☐ Letter of verification from Dept. Director/Section Head or equivalent indicating employment or appointment to research projects

☐ Curriculum Vitae

☐ Copy of Professional License (if applicable)

☐ Copy of government or school-issued photo identification

☐ Basic Life Support (BLS) Certification (applicable if affiliate will have patient contact)

Expiration: _____/_____/__________

☐ Immunization Records*

- ☐ MMR Titer Results or MMR x 2 vaccinations
- ☐ Hepatitis B vaccine or antibody titers
- ☐ Varicella titer or vaccination
- ☐ Flu vaccination (required annually)

  Date: _____/_____/__________

- ☐ COVID-19 vaccinations

  Dates: #1 _____/_____/__________ #2 _____/_____/__________

☐ TB skin test/blood test (required per UMCNO Employee Health Guidelines)

Date: _____/_____/__________

☐ Background screening*

☐ Drug screening*

☐ Good Clinical Practice (GCP) CITI training certificate

☐ Biomedical Researchers CITI training certificate

Note: *A letter of good standing from your academic institution (including for medical students) will be accepted in lieu of your background screening, drug screening and immunization records (except for annual flu vaccine, COVID-19 vaccine, and TB test/questionnaire). Affiliate is responsible for providing updates to the UMCNO Office of Research before expirations.

This checklist and all accompanying documentation must be emailed in one single email to UMC-ResearchCredentialing@lcmchealth.org. Contact the UMCNO Office of Research at 504-702-2440 with any questions.

SCOPE OF PRACTICE FOR RESEARCH AFFILIATE

The Scope of Practice is specific to the duties and responsibilities of each research affiliate. The affiliate is authorized to conduct research involving human subjects with the responsibilities approved on the following page in conjunction with approved research protocols. The Department Director, Section Head or equivalent is responsible for the conduct of the employee and must sign the Scope of Practice.

Please check the appropriate boxes for routine duties that apply to the research affiliate's designated credential affiliation. Affiliates will be authorized to perform only the duties and procedures listed on protocols fully approved by an IRB **and** UMCNO's Research Review Committee.

Research Duties	Affiliate Tasks
Regulatory document preparation/submission to IRB, UMCNO Office of Research, Sponsor	
Develops and/or implements study recruitment methods	
Screens patients for study eligibility by reviewing patient health records or interviewing patients	
Provides education related to study to patient, family, and UMCNO staff as necessary per protocol	
Obtains informed consent from research subject and uploads into EPIC	
Checks and records vital signs (check-off needed for non-nurses)	
Performs venipuncture to obtain study specimens **(Nurses only)**	
Collects human specimens (i.e., blood, urine, sputum, etc.)	
Hand delivers study drug dispensed by research pharmacy to research subject	
Provides subject education/instruction on use of study medication/device, side effects, and how to notify researcher of adverse drug reactions	
Documents research notes	

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SCOPE OF PRACTICE

RESEARCH AFFILIATE'S STATEMENT

This Scope of Practice outlines research duties I am permitted to undertake in conjunction with approved protocols. I understand that all research performed at UMCNO must be approved by the IRB **and** UMCNO's Research Review Committee. If I have questions or concerns, I will contact the UMCNO Office of Research at UMC-ResearchCredentialing@lcmchealth.org I also understand that performing tasks beyond my scope of practice may lead to termination of credentials. I agree to abide by all applicable hospital policies including training on EPIC per UMCNO IT and research documentation for the EMR training conducted by the Office of Research.

____
Printed Name of Research Affiliate

______________________________ ______________________________
Signature of Research Affiliate **Date**

I certify that this affiliate possesses the skills to safely perform the aforementioned research duties. Both the affiliate and I acknowledge this Scope of Practice. I agree to abide by all applicable UMCNO policies.

____
Printed Name of Dept. Director/Section Head

______________________________ ______________________________
Signature of Dept. Director/Section Head (NOT PI) **Date**

LCMC NETWORK and ELECTRONIC MEDICAL RECORD (EMR) ACCESS

Name: ____ **Date of Birth:** _____/_____/__________

Institutional Email: ______________________________________

Will you require DUO Remote access? ☐ Yes ☐ No **Expected Access Start Date:** _____/_____/__________

Note: Typical LCMC Network and EMR Access is granted to affiliates for 180 days. Affiliate is responsible for renewing all requirements prior to expiration or your UMCNO IT Accesses may be rescinded.

After LCMC network credentials are provided by the UMC Office of Research to the affiliate, EPIC training will be assigned with an email notification from UMCNO IT to the affiliate and must be completed before successful EPIC login. This is a multi-step process and may require several days.

Once login credentials are issued from our office, and all trainings, including Office of Research departmental trainings are completed, you will be approved to conduct research at UMCNO.
Please contact the UMCNO Help Desk at 504-702-HELP (4357) for any LCMC Network or EMR/EPIC issues.

By signing this application, I agree to the following:

- I acknowledge that I am accountable for all activity attributable to my login ID. Accordingly, I will not share my login ID and I will guard my password and log off UMCNO computers.
- I will use my login ID to perform authorized activities only related to research.
- If I abuse or gain unauthorized access to computer resources, I understand that UMCNO may immediately revoke my computer privileges and report my conduct to law enforcement authorities.
- I understand that, upon termination of employment, non-renewal of contract, or loss of active student status,UMCNO will delete my login ID and my data.
- I understand the importance of privacy and confidentiality of information pertaining to research, particularly that sponsored by industry partners. I pledge to access and handle all sensitive data with the appropriate care and precautions.
- I will protect the confidentiality, integrity, and availability or protected health information (PHI) while adhering to the Health Insurance Portability and Accountability Act (HIPAA) Security Rule requirements.

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Printed Name of Research Affiliate

______________________________________ ________________
Signature of Research Affiliate **Date**

____
Printed Name of Dept. Director/Section Head

______________________________________ ________________
Signature of Dept. Director/Section Head (NOT PI) **Date**