Credentialing Application - Research

Please complete this application and e-mail to: Lisa R. Trevino, PhD, Vice President of Research and Development at lis.trevino@dhr-rgv.com

Checklist: Please provide the following information as listed.

- ☐ Completed application
- ☐ Resume/CV
- ☐ Certificates of completion for required CITI training modules:
  - Good Clinical Practice (if applicable and requested by sponsor)
  - Human Subject Research Protection
  - Conflict of Interest
- ☐ Proof of negative TB test

I. Personal Information

Name: _____
First Middle Initial Last

Mailing Address: _____

City:_____State:_____Zip: _____

E-mail:_____Work Phone:_____

Cell Phone: _____

Emergency Contact:_____Phone:_____

Affiliated Institution:_____

Department:_____ Position:_____

Please indicate your credentials:

☐ MD	☐ BSN
☐ PhD	☐ BS/BA
☐ RN	☐ AS/AA
☐ ARNP	☐ CCRC
☐ CCRA	☐ Other _____

II. Professional Information

Affiliation:_____
(Name of Group/Department you will be working With at DHR Health)

Please list the Principal Investigators or Physicians that you intend to work with at DHR Health:

_____

Please indicate the types of studies that you expect to be involved in at DHR Health:

☐ Chart Review (Retrospective or Prospective or Both) ☐ Registry
☐ Observational ☐ Survey ☐ Drug Trials
☐ Device Trials ☐ Industry Sponsored ☐ Investigator Initiated

Principle Investigator Acknowledgment

I understand that my involvement with human research is to be conducted under the ethical principles of respect for all persons, beneficence, and justice. I am committed to protecting the privacy of patient health information during any data collection that I am responsible for and am committed to minimizing risk for any patients that I care for during the conduct of the research that I am involved in. I will conduct all research related activities according to the DHR and IRB approved study protocol and will maintain patient safety at the forefront of all research activities with which I am involved. I also I certify to the best of my knowledge that the information included in this application is accurate under the terms and conditions of this Agreement.

_____ _____

Applicant Signature **Date**

Confidentiality Statement

I, _____ will be participating in research studies that are to be conducted at Doctors Hospital at Renaissance and/or Doctors Hospital at Renaissance-affiliated clinics and facilities. Any and all DHR related studies that I serve on as a research staff member will be approved by the Doctors Hospital at Renaissance research review committee (s) and a DHR Institutional Review board of record. I realize that, in the course of my work, I may be exposed to confidential information regarding patients. I understand that any and all patient information is confidential and protected under State and Federal regulations governing hospitals and patient rights. I understand and agree that I will not access and/or disclose any protected patient health information, unless such access and/or disclosure is done in accordance HIPAA and Texas law regarding the privacy of patient information. I understand that access to DHR's patient health records (in paper and electronic) will only be allowed if the patient has authorized such access pursuant to a written authorization and/or such access is allowed pursuant to 45 CFR 164.512, the federal HIPAA regulations governing access to patient information without patient authorization for research purposes. I understand that credential application approval, the granting of a DHR ID badge and general computer access, and other privileges do not grant me full and automatic access to patient information. Violations of these laws and DHR policies with respect to patient health information will carry strict penalties. I further understand that no patient names or data may be abstracted or removed from the hospital other than as identified in the research protocols and approved in the Doctors Hospital at Renaissance HIPAA Authorizations.

I understand the above conditions and agree to be in full compliance.

_____ _____

Signature Date

_____

Print Name

Statement of Good Standing

This statement is to certify that _____, the aforementioned individual listed in this application is a member of _____ (Institution), and is currently in good academic and employment standing. I also acknowledge that the documents listed below are in the possession of the Institution and will be provided to the DHR Health Institute of Research and Development upon request. These documents are inclusive but not limited to the following:

- ☐ Copy of Immunization/Vaccination record (fully validated) inclusive of:
  - Hepatitis B (3 dose series)
  - MMR
  - Varicella (2 dose series OR titers with IGG levels for those with history of disease)
  - Tetanus/Diphtheria (received within last 10 years)
  - PPD (valid for 1 year from administration, x-rays 5 years)
  - Seasonal influenza
- ☐ Verification of employment background check
- ☐ Verification of Institutional malpractice coverage
- ☐ Verification of any and all professional licenses.
- ☐ Contact information for professional references

I understand and agree to be in full compliance.

_____ _____

Signature (Institute Signatory Official) Date

_____

Title

_____

Print Name