Full Application for Non-Fairview Employed Research Staff

All non- Fairview research personnel utilizing patients or patient data within a Fairview facility for research purposes must complete this application. It is the responsibility of the researcher to update this application if he/she has a change in employment or supervisor.

Name of Applicant: _____ Last 4 digits of SSN: _____
Last, First, Middle

Work Address: _____ Daytime Phone: _____

Email Address: _____ Evening/Other Phone: _____

- **Attach a copy of your current CV/Resume.**

Current Credentials: ☐ RN ☐ LPN ☐ CNA ☐ Phlebotomist ☐ Other _____

- **Attach a copy of your current License(s)/Certification(s) for each credential checked above**

Employer: ☐ U of MN Department: _____
☐ Other: _____

Supervisor: _____ _____
Name Title

_____ _____ _____
Phone Pager Email

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1. Indicate the specific hospital, hospital unit, and/or clinics in which you will be performing research activities. *Applications listing a hospital without units will not be accepted*. If you are solely reviewing medical records, please indicate the department(s) on which you are focused.

Hospital:
Units:

Hospital:
Units:

Clinics/Other:

2. Select the Fairview information system(s) you will be using in your research role. Indicate if you already have access to the system or if you need to establish access to complete your research.

System (Function)	I have access	I need to establish access
EPIC (Fairview's electronic medical record)	☐	☐
Person to be 'set up like' in EPIC, if known:		
SecureGateway (for remote access to EPIC)	☐	☐
Other:	☐	☐
Other:	☐	☐

Rev. 09/02/2011

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3. Select all the research tasks or procedures you will perform. Indicate when you completed the requirements associated with your level of patient involvement. **Additional documentation required.*

No Patient Contact			
Tasks	**Requirements**	**Date**	**Attached?**
☐ Medical records review	HIPAA		
☐ Medical record documentation	Human Subjects' Protection (e.g. CITI)*		☐
☐ Other:			

Patient Contact			
Tasks	**Requirements**	**Date**	**Attached?**
☐ Obtain informed consent	HIPAA		
☐ Survey administration	Human Subjects' Protection (e.g. CITI)*		☐
☐ Vital signs (incl. CO_2 stats)	Fairview Required Learning*		☐
☐ Other:	Background Study Forms *(required for badge)**		☐
☐ Other:	License/ Certification Study Forms*		☐
	Proof of Immunizations*		☐

Patient Intervention			
Tasks	**Requirements**	**Date**	**Attached?**
☐ Blood draw: vein, heel, finger	HIPAA		
☐ Other biological sample collection	Human Subjects' Protection (e.g. CITI)*		☐
☐ IV access	Fairview Required Learning*		☐
☐ IV placement	Background Study Forms *(required for badge)**		☐
☐ Medication administration	License/ Certification Study Forms*		☐
☐ Other:	Proof of Immunizations*		☐
☐ Other:	Hazardous Waste		
	Bloodborne Pathogens		
	Patient Identification		
	Medication Administration *(if applicable)*		

Please allow THREE (3) weeks from the time of submission for processing

I certify that I have provided correct and current information regarding my application to provide ancillary clinical professional services at Fairview Health Services.

Signature of Applicant _____ Date _____

Signature of Supervisor _____ Date _____

Submit Completed Application to Fairview Research Administration

Fax	Email	Intercampus Mail	U.S. Post
612-672-7691	research@fairview.org	Research Administration Energy Park Building	2344 Energy Park Drive St. Paul, MN 55108

Rev. 09/02/2011