LSOCA

Data Entry Certification/Decertification

Purpose: To record information for data entry certification or decertification.

When: Whenever data entry certification is requested or after termination of data entry person's employment.

By whom: Person requesting certification or decertification and/or clinic coordinator/director.

Instructions: Read LSOCA Data System Manual and complete the on-line LSOCA Data System Tutorial. Complete the Data Entry Certification/Decertification (DC) form and fax to Coordinating Center at (410) 955-0932. A separate DC form must be completed when Data Entry technician is no longer active in LSOCA.

A. Certification information

1. Clinic ID code: ____ ____ ____ ____

2. Date form completed:

____ ____–____ ____ ____–____ ____
day mon year

3. Name of person being certified/decertified *(please print):*

_____
name

4. Personal Identification ID#
(four to six alpha numeric characters that are used to log into electronic data system which are created when completing the tutorial):

____ ____ ____ ____ ____ ____

5. Office contact information

a. Address:

_____

_____

_____

b. Phone number:

_____

c. Fax number:

_____

d. E-mail address:

_____

6. Is this form being completed for the request of data entry certification or for data entry decertification *(check only one):*

Data entry certification (1)
Data entry decertification (2)

9. ____

7. I have read the LSOCA data system manual and completed the data system tutorial:

Yes (1) No (2)

(All requirements must be completed before certification will be given)

8. Confidentiality statement:

I have read the Longitudinal Study of Ocular Complications of AIDS Data System Manual and completed the Data System Tutorial.

I understand that the information provided by study patients is not to be used in any way that will compromise their rights to confidentiality or privacy and that failure to respect these rights may result in my dismissal from LSOCA.

I understand that sharing my data system username and password with anyone constitutes a compromise in patient confidentiality.

I understand the need for high standards of integrity in the data collection and recording process. Further, I understand that any shortcomings in this regard on my part can have an impact on the credibility of LSOCA and may result in my dismissal from LSOCA.

I understand that this is a collaborative study and that any presentations or publications made before the data are placed in the public domain are subject to the review and approval of the LSOCA Study Officers.

_____
Signature of individual named in item 3.

Clinic ID code: ____ ____ ____ ____

B. Clinic coordinator/director assurance

9. Date form reviewed:

____ ____–____ ____ ____–____ ____
day mon year

10. Clinic coordinator/director ID: ____ ____

11. Clinic coordinator/director signature:

_____

NOTE: *Items 9 through 11* **must** *be completed:*

Fax this form to:
SOCA Coordinating Center
Fax (410) 955-0932
615 North Wolfe St., Room 5010
Baltimore, Maryland 21205

C. Coordinating center use

12. Date form reviewed:

____ ____–____ ____ ____–____ ____
day mon year

13. Action taken:

_____

_____

14. Person reviewing this form *(please print):*

_____