Personnel Certification

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Purpose: To request certification in one or more SOCA functions (except ophthalmic surgeons). When: Whenever certification for personnel is requested. By whom: Clinic staff member requesting certification; Clinic Director must sign this form. Certification requirements: See instructions in SOCA General Handbook for certification procedures. Instructions: Send this form with any applicable practice forms to the Coordinating Center. 5. Functions for which certification is being A. Identifying information requested (check all that apply) 1. Clinic ID code: **a.** Clinic Coordinator: (**b.** Internist: 2. Name of person requesting certification c. Research Nurse/Nurse Practitioner: *(please print):* (d. Ophthalmologist: name e. Photographer: (**3.** Identification ID# **f.** Visual acuity examiner: (Print "N" if person has not been issued an ID#): g. Goldmann visual field examiner: h. Humphrey visual field examiner: (4. Contact information i. Contrast sensitivity examiner: a. Address: j. Data system operator:

b. Phone number:

c. Fax number:

d. E-mail address:

B. Training information

I. Other (specify):

6. Name of SOCA staff member training person named in item 2.:

k. Specimen lab technician:

name

7. All personnel: *I have read the protocol and patient consent state ment for the Longitudinal Study of Ocular Complications of AIDS.*



- 8. Specific personnel: Certify that you have reviewed the following documents (check only those that apply)
 - a. Clinic coordinator/physician/nurse (LSOCA Handbook and applicable forms): Yes
 - **b.** Fundus photographer (Fundus photography protocol and applicable forms): Yes No
 - c. Visual acuity examiner (Visual acuity protocol and applicable forms): (1) (2) (2)
 - **d.** Goldmann visual field examiner (Goldmann field protocol and applicable forms): Yes No
 - e. Humphrey visual field examiner (Humphrey field protocol and applicable forms): Yes No
 - f. Contrast sensitivity examiner (Contrast sensitivity protocol and applicable forms): Yes
 - g. Data system operator (Data system tutorial): (Ves (No
 - **h.** Specimen Lab Technician (LSOCA Handbook pages applicable to specimen processing/freezeing, and specimen checklist): Yes No

Clinic ID code:

C. Personnel assurance and identifying

information

No

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Section C is to be completed by the individual named in item 2.

9. Personnel assurance:

I have read the Longitudinal Study of Ocular Complications of AIDS Protocol and I understand and agree to abide by the design tenets of the study.

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 SOCA.

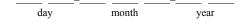
I understand the need for high standards of integrity in the data collection and recording process. Further, I understand that any shortcomings in this regard on my part can have an impact on the credibility of SOCA and may result in my dismissal from it.

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

Signature of individual named in item 2.

D. Clinic director assurance

10. Date form reviewed:



- **11.** Clinic director ID:
- **12.** Clinic director signature:

NOTE: *Items 10 through 12* **must** *be completed: Mail this form to:*

SOCA Coordinating Center 615 North Wolfe St., Room 5010 Baltimore, Maryland 21205

E. Coordinating center use			
13. Date form reviewed:			
	day	month	year
14. Action taken:			
15. Person reviewing this form <i>(please print)</i> :			

Clinic ID code: _____ ____