Personnel Certification

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.

A. Identifying information

1. Clinic ID code: ___ ___ ___ ___

2. Name of person requesting certification *(please print):*

____
name

3. Identification ID# *(Print "N" if person has not been issued an ID#):*

___ ___

4. Contact information

a. Address:

____

____

____

b. Phone number:

____

c. Fax number:

____

d. E-mail address:

____

5. Functions for which certification is being requested *(check all that apply)*

a. Clinic Coordinator: (1)

b. Internist: (1)

c. Research Nurse/Nurse Practitioner: (1)

d. Ophthalmologist: (1)

e. Photographer: (1)

f. Visual acuity examiner: (1)

g. Goldmann visual field examiner: (1)

h. Humphrey visual field examiner: (1)

i. Contrast sensitivity examiner: (1)

j. Data system operator: (1)

k. Specimen lab technician: (1)

l. Other *(specify):* (1)

____

B. Training information

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

____
name

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

Yes (1) No (2)

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 (1) No (2)

b. Fundus photographer
(Fundus photography protocol and applicable forms): Yes (1) No (2)

c. Visual acuity examiner
(Visual acuity protocol and applicable forms): Yes (1) No (2)

d. Goldmann visual field examiner
(Goldmann field protocol and applicable forms): Yes (1) No (2)

e. Humphrey visual field examiner
(Humphrey field protocol and applicable forms): Yes (1) No (2)

f. Contrast sensitivity examiner
(Contrast sensitivity protocol and applicable forms): Yes (1) No (2)

g. Data system operator
(Data system tutorial): Yes (1) No (2)

h. Specimen Lab Technician
(LSOCA Handbook pages applicable to specimen processing/freezeing, and specimen checklist): Yes (1) No (2)

C. Personnel assurance and identifying information

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:

____ ____ – ____ ____ ____ – ____ ____
day month year

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 *(please print)*:

____