COLUMBIA
COLUMBIA UNIVERSITY
IRVING MEDICAL CENTER

Department of Medicine
VISITOR CHECKLIST
CUIMC Short-Term Visitors / Visiting Student Interns (VSI)

Full Legal Name (Last, First, MI)**:** _____

Division: Columbia Center for Translational Immunology _____ Visit Start Date: _____

Visitor Requests in the Department of Medicine may incur the following fees, as applicable

- Departmental Administrative Processing Fee: $500 (*not applicable to CU Students and Paid Visiting Student Interns*)
- CUIMC Drug Screening Test Fee
- CUIMC Criminal Background Check Fee
- CUIMC Medical Fitness Attestation Fee
- Domain/Exchange Email Fees – processed directly via the Division

Notes:

- **Visitors may be subject to pre-employment processing based on Special Indicators identified on the registration form.**
- CU employees that will interact alone with minors will be subject to a criminal background check.
- Visitors requiring access to patient records or protected health information must first complete HIPAA training.

The following documentation is required four (4) weeks prior to the Visit start date

- ☐ **Personal Information Form:** *Must be signed by Divisional Administrator/Authorized Designee*
- ☐ **Visitor Registration Form** *(Enclosed): Must be signed by Visitor and PI/Sponsor*
- ☐ **Minor Visitors Parental Consent Form** *(Enclosed)***:** *Required for participants under 18 years of age*
- ☐ **Confirmation of Protection of Minor Training:** *Required for Sponsors and Supervisors of Visitors that are under age 18. Please contact Ursula Bollini (ub2@columbia.edu) directly to make training arrangements.*
- ☐ **Current CV/Resume**
- ☐ **CUIMC Confidentiality Agreement** *(Enclosed): Must be signed by Visitor*
- ☐ **Non-Physician Visitor Attestation of Medical Fitness (for 90 days or less)** *(Enclosed)***:** *Applicable if any Special Indicators are checked off on the Visitor Registration Form and the assignment is for 90 days or less. This form must be completed by Visitor and their caring physician in its entirety; WHS will not process incomplete forms.*
- ☐ **Copy of School/Government issued Photo ID:** *If visiting from outside the USA, Visitor must present original* **Foreign Passport with current I-94 Document/Entry Stamp**
- ☐ **B1/WB Visa Letter for International Visitors** *(Template Enclosed)***:** *This letter must be provided to International Visitors so they may obtain proper visa prior to entry into the United States)*

*ADDITIONAL DOCUMENTATION FOR **VISITING STUDENT INTERNS** ONLY:*

- ☐ **Proof of Current Student Status** *(ie. student transcript, letter from the school)*
- ☐ **Sponsored Program Documentation,** including **Proof of Stipend Award**
- ☐ **Stipend Form** *(Enclosed): If applicable*

Submit complete registration packets online via JIRA at https://jira.surgery.columbia.edu/servicedesk/customer/portal/18.

Authorization for a temporary identification badge and/or UNI will be issued once the Visitor has been cleared by Human Resources or the Office of Faculty Affairs.

COLUMBIA
COLUMBIA UNIVERSITY
IRVING MEDICAL CENTER

Department of Medicine
PERSONAL INFORMATION FORM
CUIMC Short-Term Visitors / Visiting Student Interns (VSI)

PART I – TO BE COMPLETED BY VISITOR

Full Legal Name (Last, First, MI)**:** _____

Date of Birth: _____ (*M/D/YYYY*) **Gender:** ☐Female ☐Male

USA Home Address: _____ **USA Phone:** _____

City, State, Zip: _____ **Mobile Phone:** _____

Email: _____

Visiting Student Interns Only

Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed

Marital Status Date: _____ (*M/D/YYYY*)

Ethnicity/Race: Hispanic/Latino? ☐Yes ☐No

Check one or more boxes: ☐White ☐Black/African American ☐Asian
☐American Indian/Alaska Native ☐Native Hawaiian/Pacific islander

Citizenship Status: ☐ USA Citizen ☐ Permanent Resident - A#: _____

☐ Visa Holder - Visa Type: _____ Expiration Date: _____ (*M/D/YYYY*)

Country of Citizenship: _____

PART II – TO BE COMPLETED BY DIVISION ADMINISTRATION

Security Access (Check either or both)**:** ☐ **CUIMC ID Badge** ☐ **UNI**

Chart String for Departmental Administrative Fee *(not applicable to current CU Students or Paid VSIs)*

Dept	Project	Activity	Initiative	Segment

Funding Source for Visiting Student Stipend

Account	Project Number	Combo Code	Percent (%)
S99			
S99			

Financial Authorization

Name: _____ **Title:** _____

Signature: _____ **Date:** _____

Columbia University
Office of Human Resources
Short Term Visitor Registration Form

To Be Completed by Visitor			
Visitor's name:			
Home address:			
City:	State:	Zip:	Cell or Home phone no.:
Affiliation (e.g. school or other entity):	☑ Visitor is over age 18 ☐ Visitor is age 14 – 18 (Requires Minor Visitors Parental Consent Form and Sponsor/Principal Investigator will require Protection of Minor Training.)		
Current employer or school:			Work or school phone no. (if applicable):
Emergency contact name:	Relationship to you:		Emergency contact phone no.:
Name(s) of family member(s) employed at Columbia University:			

I acknowledge that, as a short-term visitor, my activities are limited to observation and training and I am not eligible for compensation or any University benefits. I understand that I must abide by all University rules, policies and procedures, including, but not limited to those relating to ethical conduct, safety, confidentiality, protected health and financial information and computer usage. I understand that I should not be on-site or travel to other locations without my designated or assigned sponsor.
I understand that Columbia University, when applicable, may require me to provide a medical attestation, undergo medical clearance and/or a background check, which may include a criminal check.
Columbia University may verify all of the information provided. I release the Trustees of Columbia University in the City of New York, and its officers, faculty, students, employees, agents, and affiliates from any liability for any injury that may occur at the University or while traveling to and from the University. I understand that any false statements or misleading omissions made by me in connection with my application, or in responding to any requests for information, can be sufficient grounds for my rejection as a short-term visitor or revocation of my status as a short-term visitor.

Visitor's signature:	Date:

To Be Completed by Department		
Visitor type: ■ Research ☐ Clinical ☐ Administrative or other (non-research/clinical)		
Is this a Visiting Student Intern (Sponsored Internship)? ☐ Yes ■ No **(If yes, please refer to checklist on pg. 3)**		
Project dates (not to exceed 3 months for Research and Clinical; 1 year for Administrative) Start End		Hours per week (up to 35):
Department name: Medicine	Department Division: Columbia Center for Translational Immunology	Observing location Campus: CUMIC Building: BB Room: BB1511, BB1516, I
Supervisor name/title:	Supervisor phone no.:	Form preparer name: Anette Wu

Describe in detail the observation and/or training activities the visitor will participate in (and attach C.V. or résumé to this form).

The visitor will observe and learn basic sciences techniques in translational immunology (i.e. Flow cytometry, cell culture, cell isolation, PCR, molecular biology techniques).

If any of the following Special Indicators will be part of the visitor's training or observation activities, please check the applicable boxes and schedule the required safety or compliance training appointments using the links below:

Special Indicator (All applicable trainings must be completed **prior** to accessing observing location)	**Medical Surveillance**	**Human Subject Research Training**	**IACUC/ ICM Animal Training**	**EH&S Safety Training**	**EH&S Biosafety / BBP Training**	**Fit Testing**
☐ Interacts with patients or human subjects in NYPH or ACNC space	X	X			X	X
☐ Interacts with patients or human subjects in CUIMC space (non-hospital)	X	X			X	X
☐ Observes laboratory animal use *	X		X			
☐ Has potential blood borne pathogen exposure	X				X	
☐ Potential exposure to known infectious agents or toxins where prophylactic vaccination is available (e.g., Rabies, Varicella, Polio, Salmonella typhi, Vaccinia, diphtheria toxin, pertussis toxin)	X				X	
☐ Observe or train in these departments: Autopsy, Gross, or Anatomical Pathology, Dermatopathology, or the Anatomical Gift Morgue.	X			X		X
☐ Wears N-95 respirator	X					X
☐ Wears a full-face/half-face negative or positive pressure respirator	X					X
☐ Accesses vivarium facilities for facility support activities	X		X			
☑ Potential exposure to laboratory chemicals				X		
☐ Potential exposure to radioactive material				X		
☐ Potential exposure to lasers				X		
☐ Potential exposure to viral vectors				X	X	

Safety or compliance training links:

Medical Surveillance: http://www.cumc.columbia.edu/hr/employment or, alternatively, visitors with assignments up to 90 days may complete the Visiting Non-MD Attestation of Medical Fitness form or the Visiting MD Attestation of Medical Fitness form: http://www.cumc.columbia.edu/hr/policies-procedures
Human Subject Research and applicable safety trainings: https://rascal.columbia.edu/ **
IACUC Animal Training: https://research.columbia.edu/content/laboratory-animal-lecture **
EH&S Safety Training: https://research.columbia.edu/content/safety-trainings
Fit Testing by EH&S: call 212-305-6780

*** For minors 14-18, special approval and training required by ICM and IACUC**

**** For Rascal access, please use both Visitor and Guest designation in the Delegated Identity Administration (DIA) system**

Department and School Approvals

I have reviewed the University policy on short term visitors (https://research.columbia.edu/sites/default/files/content/EVPR/Policies/Guidelines_for_Short-term_Visitors.pdf) and I acknowledge that short-term visitors may not replace employees' positions or impair employment of University positions or collaborate in research. Activities are limited to observation and training purposes and are not eligible for compensation or any University benefits. If roles and responsibilities change from the above description, I will notify my CUIMC HR Client Manager and CUIMC's Director of the Office of Faculty Affairs or the Associate Provost for Academic Appointments, as applicable, immediately for reassessment.

PI/Sponsor Authorization:		
Print:	Signature:	Date:
Chair/Director/Department Authorization:		
Print:	Signature:	Date:
Dean's Office Authorization:		
Print:	Signature:	Date:
Executive Vice President for Arts & Sciences Authorization:		
Print:	Signature:	Date:

CU/CUIMC Final Approvals

Without the necessary final approval(s), a University ID should not be issued.

Associate/Assistant Provost-Morningside Authorization (Morningside, Lamont, Nevis):		
Print:	Signature:	Date:
Office of Faculty Affairs (CUIMC) Authorization (Not required for Administrative visitors):		
Print:	Signature:	Date:
CUIMC HR Authorization (Required for all clinical and administrative visitors, and research visitors in hospital space):		
Print:	Signature:	Date:

For Departmental Use Only

Please use this checklist as a final review before submitting this form. Misprinted or overlooked data can lead to delays.

- ☑ Medical surveillance appointment scheduled or completed attestation form attached, if applicable
- ☐ EH&S safety training complete, if applicable
- ☐ Drug screening clearance for visitors in hospital space
- ☐ Background check complete for all clinical and administrative visitors and for research visitors in Joint Commission
- ☐ Protection of Minors Training for PI/sponsor complete, if applicable: http://compliance.columbia.edu/minors.html
- ☐ University ID to be issued once final clearance is received from OFA/CUIMC HR
  -Please note University ID is to be collected by department upon end of visitor stay
- ☐ HIPAA and Security Training complete within five business days of project start date

Visiting Student Intern- Departmental Use Only

Please use this checklist as a final review before approving this form and sending clearance to the department.

FOR MORNINGSIDE: Normal procedures for approval of academic appointments should be followed.

FOR CUIMC: Departments must comply with **Joint Commission, Medical Surveillance, and any safety/privacy/ compliance training requirements** for all Visiting Student Interns.

The following documents are required and must be submitted to CUIMC OFAs (Misprinted or overlooked data may lead to delays):

- ☐ Description of Department (Sponsored) Program
- ☐ Visiting Student Intern Assignment letter (if applicable)
- ☐ Short Term Visitor Forms (including the signed/dated confidentiality agreement and, if applicable, the Parental Consent Form).
- ☐ Background Check clearance for all clinical and administrative visitors and for Joint Commission research visitors
- ☐ Drug screening clearance for visitors in hospital space
- ☐ New Personnel Action Form (PAF)
- ☐ Labor Accounting Form (LAF)
- ☐ Stipend Form
- ☐ Student Resume
- ☐ Evidence of affiliation to educational institution (ie. student transcript, letter from the school)

For CU/CUIMC Human Resources or Office of Faculty Affairs Use Only

Please use this checklist as a final review before approving this form and sending clearance to the department.

- ☐ Medical surveillance cleared or completed attestation form attached, if applicable
- ☐ Drug screening clearance for Joint Commission visitors
- ☐ Background Check complete for all clinical and administrative visitors and for Joint Commission research visitors
- ☐ Résumé attached and reviewed, for visitors age 18 and over
- ☐ Parental Consent Form complete with insurance information for visitors age 14 – 18
- ☐ Signed/dated confidentiality agreement if applicable

Columbia University Irving Medical Center
(Not for Morningside Visitors)
Confidentiality Agreement

To Be Completed by Visitor
A copy of this Agreement should be kept in the Department

As a faculty member, research officer, employee, student, affiliate, visitor or volunteer at Columbia University Irving Medical Center (CUIMC), you may have access to what this Agreement refers to as "Confidential Information." The purpose of this Agreement is to help you understand your duty regarding Confidential Information.

"Confidential information" includes information about patients, employees, or students or financial or other business or academic information relating to Columbia Irving University Medical Center. You may learn or have access to confidential information through CUIMC computer systems (which include but are not limited to the clinical, human resources and financial information systems), NewYork-Presbyterian (NYP) Hospital computer systems, through interactions with CUIMC students, staff or other faculty, or through your treatment of CUIMC patients.

As an individual having access to confidential information, you are required to conduct yourself in strict conformance with applicable laws and CUIMC policies governing confidential information. As a condition of your relationship to CUIMC, you are required to acknowledge and abide by these duties. A violation of any of these duties will subject you to discipline, which might include, but is not limited to, dismissal of your relationship (faculty appointment, employment, student, consulting, etc.) with CUIMC, in addition to legal and/or financial liability.

I understand that I may have access to electronic, printed, or spoken confidential information, which may include, but is not limited to, information relating to:

- Patients - including Protected Heath Information (PHI), records, conversations, patient financial information, etc.;
- Employees - including salaries, employment records, disciplinary actions, etc.;
- Students - including enrollment, grade and disciplinary information;
- Research - including PHI created, collected, or used for research purposes;
- CUIMC - including, but not limited to, financial and statistical records, strategic plans, internal reports, memos, peer review information, communications, proprietary computer programs, source code, proprietary technology, etc.;
- Third party information - including computer programs, client and vendor proprietary information, source code, proprietary technology, etc.;
- PHI and Personally Identifiable Information (PII) used in other contexts.

Accordingly, as a condition of, and in consideration of, my access to confidential information, I promise that:

1. I will use confidential information only as needed by me to perform my legitimate duties as defined by my relationship (faculty, employment, student, visitor, consulting, etc.) with CUIMC.

    - I will not access confidential information which I have no legitimate need to know.
    - I will not in any way divulge copy, release, alter, revise, or destroy any confidential information except as properly authorized within the scope of my relationship with CUIMC.
        - I will not misuse or carelessly handle confidential information.
        - I understand that it is my responsibility to assure that confidential information in my possession is maintained in a physically secure environment.

2. I will safeguard and will not disclose to any other person my access code (password) or any other authorization code that allows me access to confidential information. I will be responsible for misuse or wrongful disclosure of confidential information that may arise from sharing access codes with another person and/or for failure appropriately to safeguard my access code or other authorization to access confidential information.
    - I will log off computer systems after use.
    - I will not log on to a system or access confidential information to allow another person access to that information or to use that system.
    - I will report any suspicion or knowledge that my access code, authorization, or any confidential information has been misused or disclosed without CUIMC authorization.
    - I will not download or transfer computer files containing confidential information to any non-NYP/CUIMC authorized computer, data storage device, portable device, telephone, or other device capable of storing digitized data.
    - I will only print documents containing confidential information in a physically secure environment, will not allow other persons' access to printed confidential information, will store all printed confidential information in a physically secure environment, and will destroy all printed confidential information when my legitimate need for that information ends in a way that protects the confidentiality of the information.
3. I will follow CUIMC policies and procedures regarding the use of any portable devices that may contain confidential information including the use of encryption or other equivalent method of protection.
4. I acknowledge my obligation to report to the CUIMC Privacy Officer any practice by another person that violates these obligations or puts CUIMC, its personnel, or its patients at risk of a disclosure of confidential information.
5. I will only use my Columbia email account to send and receive message that may include confidential information and will not use email to send confidential information to other parties outside of Columbia/NYP without protection to prevent unauthorized access.
6. If I am involved in research, any research utilizing individually identifiable information or protected health information will be performed in accordance with federal, state, local and Institutional Review Board policies.
7. If I no longer need confidential information, I will dispose in a way that ensures that others cannot use or disclose it including following the Information Technology policy for disposal of printed confidential information or electronic equipment that may contain confidential information.
8. I understand that my communication using the Columbia University information network is not private and the content of my communication may be monitored to protect the confidentiality and security of the data.
9. I understand that my obligation under this Agreement will continue after termination of my relationship with CUIMC.
10. I understand that I have no right or ownership interest in any confidential information referred to in this Agreement. CUIMC may at any time revoke my access code, or access to confidential information. At all times during my relationship, I will act in the best interests of CUIMC.

Name (print):	Date:
Name (signature):	Department: CCTI

NewYork-Presbyterian
The University Hospital of Columbia and Cornell

Non-physician Visitor Attestation of Medical Fitness (for 90 days or less)

Part 1. Applicant: please print legibly.

Name: _____ Date of Birth: ___/___/____
Email: _____ Phone:_____
Visit start date: ___/___/____ Visit end date: ___/___/____ (**for 90 days or less**)
Visit arranged via: □New York-Presbyterian Hospital □ Columbia University Medical Center)
Direct Supervisor's Name for the visit: _____
Supervisor's Department: _____Email:_____ Phone:_____

In support of my application, I attest that:

1. During this visit I will be (check one):
   - □ providing patient care directly (*visitors hosted by NYP only*)
   - □ observing patient care
   - □ no patient care
   - □ working with animals only (ICM)

2. I have been offered Hepatitis B vaccination and (check one):
   - □ have accepted and completed the series of Hepatitis B vaccinations
   - □ declined Hepatitis B vaccination and signed the OSHA declination form. https://www.osha.gov/SLTC/etools/hospital/hazards/bbp/declination.html

3. For this flu season I have (check one):
   - □ Received the influenza vaccination. Date of last flu vaccination: __/__/__, and I will obtain an NYP Flu Sticker from WH&S.
   - □ Declined the influenza vaccination, and if I declined vaccination, I agree to wear a surgical mask in designated areas during the "mask on" period designated by the New York State Commissioner of Health

4. Regarding travel to any countries that are labeled as CDC's Warning Level 3 (Avoid Nonessential Travel) due to 2019-novel Coronavirus/SARS-CoV-2/COVID-19 or other infectious diseases (check one; if needed, check the travel country name at the following CDC website: https://wwwnc.cdc.gov/travel/notices):
   - □ I have NOT traveled to those countries over the last 14 days.
   - □ I have traveled to one of those countries over the last 14 days:
     Name of travel country: _____; travel start date __/__/__; travel end date: __/__/__

Part 2. The following must be filled out by your primary health care provider. Any attachments that will assist in the completion of this form should be sent. Attachments will only be accepted in english. Attachments cannot be used as a substitution for filling out this form. If any part of the form is incomplete or pending, you will not be allowed to start regardless of your start date.

Measles Mumps Rubella Vaccine (MMR) (1st Vaccine after 1st birthday)	OR **Measles/Rubeola Antibody** **Mumps Antibody** **Rubella Antibody**
Date 1: ___/___/___ Date 2: ___/___/___	Measles Date: ___/___/___ Result: □ Positive □ Negative Mumps Date: ___/___/___ (*Not mandatory, but strongly encouraged*) Result: □ Positive □ Negative Rubella Date: ___/___/___ Result: □ Positive □ Negative

Hepatitis B Antibody **Date**: ___/___/___ Result: **Hepatitis B Antibody** **Date**: ___/___/___ Result: □ Positive □ Negative (If neg., then HBsAg needs to be performed) **Not needed for ICM visitors**	**Hepatitis B Antigen *(within 6 months of scheduled visit start date)*** **Date**: ___/___/___ **Hepatitis B Antigen *(within 6 months of scheduled visit start date)*** **Date: ___/___/___** Result: □ Positive □ Negative (Perform only if HBsAb is negative) **Not needed for ICM visitors**	**Hepatitis C Antibody (within 6 months of scheduled visit start date)** **Hepatitis C Antibody *(within 6 months of scheduled visit start date)*** **Date**: ___/___/___ Result: □ Positive □ Negative **Not needed for ICM visitors**

Varicella Vaccination (2 Vaccines) OR **Varicella Titer** **Not needed for ICM visitors**	
Date 1: ___/___/___ Date 2: ___/___/___	Date: ___/___/___ Result: □ Positive □ Negative

2 Mantoux TB Skin Tests (PPD)

(The 1st test within prior 12 months and the 2nd test within 60 days prior to the scheduled visit start date) OR present physician documentation of completed latent Tb treatment. IGRA testing may be substituted for two-step TST.

PPD #1 (within prior 12 months of scheduled visit start date) Plant Date: ___/___/___ Read Date (48-72 hours after plant): ___/___/___ Result: _____ mm (must be documented as a numerical value)	**PPD #2** (within 60 days scheduled visit start date) Plant Date: ___/___/___ Read Date (48-72 hours after plant): ___/___/___ Result: _____ mm (must be documented as a numerical value)

If positive, chest x-ray date (within prior 12 months** of scheduled visit start date)*
Date:___/___/___ Results:_____

IGRA or Quantiferon blood test (within 60 days of scheduled visit start date)
Date: ___/___/___
Result: □ Positive □ Negative

Tdap (within the past 10 years)
Tdap Date: ___/___/___ (*Not mandatory, but strongly encouraged*)

*Medical & occupational history and physical examination were performed, and the examination was of sufficient scope to ensure that the visitor can perform his or her duties without restriction.

Confirmation Date: __/__/__ Comments: _____

*Please provide additional comments/documentation if there are any medical conditions that may affect the applicant's ability to perform his/her duty. Please write "NA" if not applicable

Confirmation Date: __/__/__ Comments: _____

Physicians Acknowledgement

- An offer for vaccination against Hepatitis B is an OSHA requirement for all healthcare personnel. Those with a negative titer who decline vaccination must sign a declination form at Workforce Health & Safety Office at Harkness Pavilion 1st Fl. New York, NY.
- S/he does not take prescribed or unprescribed drugs that may impair his/her cognition, judgment, or physical dexterity in such a way that could pose a hazard to patients.
- S/he is fully able to adhere to standard precautions, when applicable: personal protective equipment, respiratory hygiene/cough etiquette and safe infection practices.
- S/he confirmed that s/he has not traveled to a CDC designated Ebola Virus affected country in the past 21 days. For a list of affected countries please see the CDC website: http://wwwnc.cdc.gov/travel/notices

I attest that based on physical examination and medical history, the applicant named is free of any health impairment, including habituation or addiction to alcohol or drugs or other behavior altering substances, that could pose a potential risk to patients or impede the applicant's ability to perform his/her duties.

Provider's Signature:_____ Date*:___/___/___
***Date cannot be earlier than 3 months prior to the applicant's start date**

Print Name & Title:_____

Provider License #:_____ Phone:_____
Provider's Office Address:_____

Visitors Acknowledgement

1. I am fully able to adhere to standard precautions, when applicable: personal protective equipment, respiratory hygiene/cough etiquette and safe infection practices.
2. I do not take prescribed or unprescribed drugs that may impair my cognition, judgment, or physical dexterity in such a way that could pose a hazard to patients
3. I have not traveled to a CDC designated Ebola Virus affected country in the past 21 days. For a list of affected countries please see the CDC website: http://wwwnc.cdc.gov/travel/notices

I understand that to be a NYP/Columbia Medicine non-physician visitor, I must be free of any health impairment, including habituation or addiction to alcohol or drugs or other behavior altering substances, that could pose a potential risk to patients or impede my ability to perform my duties. I hereby attest that I am free of any such impairment.

Applicant's Signature _____ Date*: ___/___/_____
***Date cannot be earlier than 3 months prior to your start date.**

Comments: _____ Date: __/__/__

Part 3. Applicant: please submit this form to Workforce Health & Safety.

==========

WHS Reviewer Name: _____Signature: _____ Date reviewed: ___/___/_____