Arrowhead Regional Medical Center
Institutional Review Board

Add Sub-Investigator Request Form

Date:

Protocol Number:

Protocol Title:

Principal Investigator:

Sub-Investigator Information

Name: _____

Status (*select one*):

☐ **Resident**	☐ **Faculty**	☐ **Medical Student** Year:	☐ **Nurse**	☐ **Other:**
Year:	Dept.:	School Name:	Dept.:	

Sub-Investigator Email: _____

Start Date: _____

Principal Investigator Printed Name: _____

Principal Investigator Signature: _____

*Please Attach Signed Confidentiality Agreement for Sub-Investigator

**Attach a copy of CITI Certificate for IRB office

ARROWHEAD REGIONAL MEDICAL CENTER

CONFIDENTIALITY AGREEMENT FOR RESEARCHERS

USE OF CONFIDENTIAL INFORMATION AT ARMC:

Arrowhead Regional Medical Center (ARMC) is committed to conducting business in compliance with all applicable laws, regulations and ARMC's policies. The Medical Center has adopted the Uses and Disclosures of Protected Health Information Policy (Administrative Policy # 1000.07) to set forth its compliance with those standards established by the Department of Health and Human Services under the Health Insurance Portability and Accountability Act (HIPAA) of 1996 regarding the privacy of individually identifiable health information.

As part of a research team (volunteer, student, temporary agency employee, clinical or non-clinical observer or visiting faculty) you may come in contact with a great deal of confidential information including Protected Health Information (PHI). It is your responsibility to see that you treat such matters pertaining to PHI in the strictest confidence. PHI must not be disclosed to or used by non-authorized individuals for purposes other than Treatment, Payment or Healthcare Operations (TPO).

It is important that the entire ARMC community share a culture of respect for confidential information. To that end, if you observe access to or sharing of confidential information that is or appears to be unauthorized or inappropriate, please try to make sure that this use or disclosure does not continue. This might include advising the person involved that they may want to check the appropriateness of the use or disclosure with ARMC Risk Management department or Institutional Review Board (IRB). It may also involve letting your Attending, Office of Research and Grants, or others in authority at ARMC know about the issue or possible issue.

I UNDERSTAND AND AGREE THAT:

I will not look at any protected data involved or interact with patients involved in the study until I have been approved as a researcher by the IRB. This information may include, but is not limited to, information on patients, employees, plan members, students, other workforce members, donors, research, or financial and business operations. Some of this information is made confidential by law (such as "protected health information" or "PHI" under the Federal Health Information may be in any form, e.g. written, electronic, oral, overheard or observed.) I also understand that access to all confidential information is granted on a need-to-know basis. A need-to-know is defined as information access that is required in order to engage in the research project that I am assigned to.

It is my legal and ethical responsibility to protect the privacy, confidentiality and security of all confidential information, including PHI, while at ARMC. I will not share the PHI with those outside of ARMC unless they are part of the research study and any data sharing outside the ARMC campus should be de-identified per policy 1000.26 with all names, medical record numbers and any other identifying information removed. I will not remove any confidential information from ARMC except as permitted by ARMC policies, and in accordance with the IRB HIPAA agreement that was agreed upon for this particular study.

I must log off of my computer system if I am away from my workstation so PHI cannot be accessed by unauthorized individuals. I will not disclose my password, or allow any other person to use my access/ID badge/user ID, and will not access another individual's access/ID badge/user ID **EVEN IF THEY ARE A PART OF THE STUDY.** I further understand that I must protect confidential information, patient information or any document that may contain PHI by securing it in a locked cabinet or office. I agree to discuss confidential information only in the work place and only for job related purposes and to not discuss such information outside of the work place or within hearing or other people who do not have a need-to-know about the information.

If I knowingly violate this agreement, I will be subject to reprimand and failure of the rotation. In addition, under applicable law, I may be subject to criminal or civil penalties.

I hereby acknowledge that I have read and understand the foregoing information and that my signature below signifies my agreement to comply with the above terms. In the event of a breach or threatened breach of the Confidentiality Agreement, I acknowledge that ARMC may, as applicable and as it deems appropriate, pursue disciplinary action up to and including my termination from ARMC.

NEW Sub-Investigator (print)	NEW Sub-Investigator Signature	Date