Welcome

This site is a collection of web link resources for UAMS faculty that includes selected links to the University of Arkansas Board of Trustees Policies Statements, UAMS Administrative Guide Policies and Procedures, and UAMS Administrative Memoranda.

The sets of links are not intended to be exhaustive lists, but rather those most commonly sought. Where appropriate, links to the original source are provided for those who wish to conduct exhaustive searches, as well as links to resources for further information, such as campus departments.

While not a replacement for the UAMS Faculty Handbook, this site does serve as a guide to many of the same questions. We hope you will find the site useful, and please provide feedback and suggestions by going to the "contact us" page of this site.

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B. University of Arkansas for Medical Sciences
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10/06/2005
Welcome to the University of Arkansas System

Embracing and expanding the historic trust inherent in the land-grant philosophy, the University of Arkansas provides communities in Arkansas with access to academic and professional opportunities, develops intellectual growth and cultural awareness in its students, and applies knowledge and research skills to an ever-changing human condition. Providing the state's only legal, medical, and architectural education as well as the primary engineering education in the state, the University of Arkansas also offers 188 graduate programs in 24 academic areas including teaching, business, engineering, medicine, law and agriculture.

As the sole source of comprehensive agricultural research and extension services, the University conducts most of the state's federally funded research. With over 42,000 students and 13,700 employees, the University of Arkansas System has an aggregate annual budget of over $1.1 billion. While the University is a single corporate entity under the laws and Constitution of the State of Arkansas, the President, Chancellors, and Vice President of Agriculture delegate their authority broadly throughout the University and its operating divisions.

Our Past, Our Future . . .
The Arkansas General Assembly established the University in Fayetteville in 1871 as the Arkansas Industrial University, and under the authority of the Morrill Act of 1862, it became the state land-grant institution and first state-assisted college in Arkansas. On opening day, January 22, 1873, there were four teachers and eight students.

In 1873 the University established a campus in Pine Bluff, which was designated as a land-grant campus of the University from 1875 until 1927, and then uniting again with the System in 1972. In 1879, the University accepted responsibility for academic management and operation of a privately established not-for-profit medical campus in Little Rock. This campus merged into the University System in 1911, and is now known as the University of Arkansas for Medical Sciences.

In 1969, Little Rock University joined the UA System, becoming the University of Arkansas at Little Rock. In 1971, the Monticello campus was added, dissolving its predecessor, Arkansas A & M College. Phillips Community College in Helena joined the UA System in 1996, later adding campuses in Stuttgart and DeWitt. Also in 1996, Red River Technical College in Hope joined the System and was renamed the University of Arkansas Community College at Hope. In 1998, Gateway Technical College in Batesville joined the System and was renamed the University of Arkansas Community College at Batesville. In 2001, Petit Jean College joined the System and was renamed the University of Arkansas Community College at Morrilton. Also in 2001, Cossatot Technical College joined the System and was renamed Cossatot Community College of the University of Arkansas. On January 1, 2002, Westark College joined the System and was renamed University of Arkansas at Fort Smith. The most recent additions to the UA System are the Arkansas School for Mathematics, Sciences, and the Arts on January 1, 2004, and the University of Arkansas Clinton School of Public Service on July 1, 2004.

Keenly aware of the continually changing world, the University is committed to study and anticipate an evolving society. By updating our offerings and featured programs accordingly, we prepare our students to be leaders of tomorrow.
Our institutions are designed to serve the people of the state effectively and provide national leadership as well. While the cooperative strength and combined resources of our institutions are a plus for the University of Arkansas, the unique attributes of each institution are also a major advantage. The individual locations offer significantly different programs, emphasis, student life and community opportunities.
Campuses & Affiliates

The Board has delegated administrative authority for the University’s operations to the System President, B. Alan Sugg. Each Chancellor is responsible for the programs and activities of the respective campus.

Academic Institutions

University of Arkansas, Fayetteville
Year Established: 1871
Chancellor: John White
www.uark.edu

University of Arkansas at Pine Bluff
Year Established: 1873
Joined U of A System: 1972
Chancellor: Lawrence A. Davis
www.uapb.edu

University of Arkansas for Medical Sciences
Year Established: 1879
Joined U of A System: 1911
Chancellor: I. Dodd Wilson
www.uams.edu

University of Arkansas at Little Rock
Year Established: 1927
Joined U of A System: 1969
Chancellor: Joel Anderson
www.ualr.edu

University of Arkansas at Monticello
Year Established: 1909
Joined U of A System: 1971
Chancellor: Jack Lassiter
www.uamont.edu

Phillips Community College of the U of A
Year Established: 1965
Joined U of A System: 1996
Chancellor: Steven Murray
www.pccua.edu

U of A Community College at Hope
U of A Community College at Batesville  
Year Established: 1975  
Joined U of A System: 1997  
Chancellor: Tony Kinkel  
www.uaccb.edu

U of A Community College at Morrilton  
Year Established: 1961  
Joined U of A System: 2001  
Chancellor: Nathan Crook  
www.uaccm.cc.ar.us

Cossatot Community College of the U of A  
Year Established: 1975  
Joined U of A System: 2001  
Chancellor: Frank Adams  
www.cccua.edu

University of Arkansas at Fort Smith  
Year Established: 1928  
Joined U of A System: 2002  
Chancellor: Joel Stubblefield  
www.uafortsmith.edu

Arkansas School for Mathematics, Sciences, and the Arts  
Year Established: 1993  
Joined U of A System: 2004  
Director: John Measel  
http://www.asmsa.net

University of Arkansas Clinton School of Public Service  
Year Established: 2004  
Dean: Senator David Pryor  
www.clintonschool.uasys.edu

Divisions

Division of Agriculture  
Vice President for Agriculture: Milo Shult  
http://division.uaex.edu/
Units

Arkansas Archeological Survey
Year Established: 1967
Joined U of A System: 1967
Survey Director: Thomas J. Green
www.uark.edu/campus-resources/archinfo/

Criminal Justice Institute
Year Established: 1988
Director: James Clark
http://www.cji.edu
The University of Arkansas System is governed by its Board of Trustees, appointed by the Governor to 10-year terms. The Board of Trustees includes the following members:

**Charles E. Scharlau, III**  
Chairman  
Fayetteville, AR  
Term ends 3-1-07

**Stanley Reed, Vice - Chairman**  
Marianna, AR  
Term ends 3-3-08

**Jane Rogers, Secretary**  
Little Rock, AR  
Term ends 3-1-06

**Carl Johnson, Assistant Secretary**  
Little Rock, AR  
Term ends 3-1-12

**James E. Lindsey**  
Fayetteville, AR  
Term ends 3-1-09

**Tim E. Hunt**  
Paragould, AR  
Term ends 3-1-10
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<td>Lynda Bertram</td>
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<td>Vacant</td>
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<td>Vice President for Academic Affairs &amp; University Relations</td>
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<td>Vice President for University Rel.</td>
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http://www.uasys.edu/directory.htm
Faculty Resources

B. University of Arkansas for Medical Sciences

About UAMS

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10/06/2005
About UAMS

The University of Arkansas for Medical Sciences (UAMS) is part of the University of Arkansas System. UAMS has about 2200 students in six academic units: the Colleges of Medicine, Pharmacy, Nursing, Health Related Professions, and Public Health and the Graduate School. UAMS also has more than 660 resident physicians completing their training at UAMS or at one of the seven Area Health Education Centers around the state.

UAMS combines the patient care resources of a state-of-the-art hospital and outpatient center with the Arkansas Cancer Research Center, Harvey and Bernice Jones Eye Institute, Donald W. Reynolds Institute on Aging, Myeloma Institute for Research and Therapy, and Jackson T. Stephens Spine and Neurosciences Institute. Arkansas Children’s Hospital and the Central Arkansas Veterans Healthcare System are affiliates of UAMS.

The outreach efforts of UAMS include seven Area Health Education Centers (AHECs) in Fayetteville, Pine Bluff, El Dorado, Texarkana, Fort Smith, Jonesboro, and Helena, Ark.; networks of senior health centers and centers for young children with special health care needs; and interactive video education and medical consultation services to community hospitals around the state. UAMS is the state’s largest basic and applied research institution, with more than $107 million in annual research funding, grants and contracts and internationally renowned programs in multiple myeloma, aging, and other areas.

One of the largest public employers in the state with almost 9,000 employees, UAMS and its affiliates, Arkansas Childrens Hospital and the Central Arkansas Veterans Healthcare System have a total economic impact in Arkansas of about $4.1 billion per year. UAMS receives less than 11% of its funding from the state. Its operation is funded by payments for clinical services (64%), grants and contracts (18%), philanthropy and other (5%), and tuition and fees (2%).

The main campus is located at 4301 W. Markham Street, Little Rock, Arkansas, 72205-7199. For more information call (501) 686-7000.

A Brief History of UAMS  Mission Statement

University of Arkansas for Medical Sciences
4301 W. Markham St., Little Rock, AR 72205

To Make an Appointment Call the Appointments Center at: 1-501-686-8000 or 1-800-942-8267
For Patient Information/Rooms, Call 1-501-686-6416
To Direct Dial a Patient Room, call 1-501-614-2 and the Room Number
For General Information and for Numbers Not Listed, Call 1-501-686-7000
For International Patient Appointments, Call 1-501-686-8071

For Information on Mailing or E-mailing UAMS Patients

Contact us with questions about the UAMS website.
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UAMS Online  Copyright Statement  Privacy Statement  Site Index

http://www.uams.edu/general_information/about.asp  11/1/2005
UAMS Vision/ Mission Statement

Institutional Vision Statement

UAMS will be a world class medical sciences center where excellence is the defining characteristic.

Institutional Mission Statement

To Teach

- The University of Arkansas for Medical Sciences prepares excellent health care professionals and scientists who are committed to high ethical and professional standards, life-long learning, and skill advancement in health care for Arkansas, the nation, and the world.

To Heal

The University of Arkansas for Medical Sciences provides comprehensive, nationally and internationally recognized, health care in many specialties and disciplines for Arkansas, the nation, and the world.

To Search

The University of Arkansas for Medical Sciences conducts pioneering research that leads to new knowledge with application and integration into the health care disciplines, systems of care public policy, and economic progress for all people.

To Serve

The University of Arkansas for Medical Sciences provides leadership and service in the health care disciplines and in public health policy for the benefit of the citizens and communities of Arkansas.

A Brief History of UAMS  About UAMS

University of Arkansas for Medical Sciences
4301 W. Markham St., Little Rock, AR 72205

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UAMS Historical Timeline

1879
In 1879, eight physicians each invested $625 to secure the charter from Arkansas Industrial University (which later became the University of Arkansas). Together, they purchased the first physical facilities, the Sperindio Restaurant and Hotel located at 113 West Second Street, for $5,000. The school opened on October 7, 1879 with 22 students. In 1880, Dr. Tom Pinson became the first graduate of the Medical Department program.

1890
In 1890, enrollment increased to eighty new students a year. A new three-story building with a lecture room and classrooms was designed, with plans to build it on Sherman Street at its northeastern intersection with East Second Street. In 1892, a bequest from Isaac Folsom of Lonoke, Ark. established the Isaac Folsom Clinic, a free clinic for indigent patients. The clinic included exam rooms, a tuberculosis clinic, a pharmacy and an operating and recovery room, as well as clinical laboratories, an amphitheater and offices for the dean and registrar. In 1899, the clinic's name changed to the University of Arkansas Medical Department.

1900
Dr. Anna A. Shoppach became the first female UA Medical Department graduate in 1901. In 1909, the UA School of Medicine's football team, the Medics, won the state championship.

1910
In 1910, the Carnegie Foundation report called for improvements in the nation's medical schools and the American Medical Association's Council on Education adopted accreditation requirements. The University of Arkansas officially assumed direction of the medical department on July 5, 1911. Also in 1911, the medical department and College of Physicians and Surgeons merged into one school. The year 1912 saw the completion of a new State Capitol, and the old State Capitol Building on Markham and Center streets was assigned to the medical school by the state legislature. From 1913 to 1915, the legislature acknowledged financial responsibility and appropriated $35,000 to fund the biennium.

In 1917, Mollie King became the first full-time female faculty member. In that same year, the Isaac Folsom Clinic relocated next to the School of Medicine to help provide patients for the School of Medicine students. Half of the funding for the new building was supplied by the Isaac Folsom bequest. The United States entered
World War I, which depleted faculty numbers and drastically reduced enrollment, putting the medical school's survival at stake.

1920

The new City Hospital was completed in 1921, and the medical school regained its accreditation. In the same year, the Old State Capitol was renamed the Arkansas State War Memorial by the state legislature. Courses in medical technology are offered by faculty of the School of Medicine in 1924. In 1929, the Wall Street Crash and the Great Depression changed the economy of the entire nation.

1930

In 1931, the state legislature appropriated $275,000 for a new medical school building. The architect and site were selected; however, bonds that would provide funding for the project never sold. President Franklin Roosevelt’s Public Works Administration began in 1933, and U.S. Senator Joseph T. Robinson encouraged building plans. In 1934, a gift of $500,000 reactivated plans for a new medical facility, which united the School of Medicine and the Isaac Folsom Clinic at a single site. Also in 1934, construction began on the building facing McAlmont Street between the City Hospital and the Carle Bentley home. In 1935, the new medical facility was complete. It accommodated 300 students on six floors and was linked with City Hospital. The Arkansas legislature assessed a new tax on beer and liquor in 1939 to fund appropriations for the School of Medicine.

1940

In 1940, a two story connection was established between the medical school facility and City Hospital. It included a waiting room for outpatients and hospital admissions, two emergency rooms, a clinical laboratory, a blood bank, an instrumentation room and a pediatrics department. Dr. W.C. Langston initiated the concept of a medical center, which began to take shape.

In 1941, Pearl Harbor was attacked, and the University of Arkansas School of Medicine blood bank was established. During 1942 and 1943, over one-third of the part-time faculty at the School of Medicine were on active duty with the military. The Division of the University of Arkansas Graduate School was established on the McAlmont campus at this time, and the first graduate program, which offered a master’s degree in biochemistry, was established in Little Rock. The Blood Bank expanded to serve the entire state in 1943.

In 1944, City Hospital was renamed University Hospital. The Medical Illustration Department was created in the Department of Anatomy in 1947. The first African American student, Edith Irby, was admitted to the School of Medicine in 1948. During that same year, the first issue of the R.O.T.C.-sponsored student newspaper, The Medico, was published.

1950
In 1950, a forty-acre tract of land on West Markham Street was formally deeded to the university by the State Hospital. That tract of land would see a great degree of development over the next fifty years. Commencement was held in Little Rock for the first time that year, instead of in Fayetteville.

In 1951, Governor Sid McMath and Senator Ellis Fagan convinced the legislature to appropriate $7.4 million for the university, using a newly passed 2-cent cigarette tax. Ground was broken for the new University Hospital in West Little Rock, the School of Pharmacy was established, and the first outpatient chemotherapy in the state was administered. The first School of Pharmacy graduation was held in 1952, and the School of Nursing was established in 1953.

In 1954, funds for a new educational building became available. Building plans included accommodations for the School of Nursing, the Departments of Pathology, Microbiology, Physiology/Pharmacology, Biochemistry and Anatomy; animal housing; a library and an auditorium. Distance learning gained a foothold in Arkansas when a black and white closed circuit TV was used for teaching in obstetrics/gynecology.

In 1955, the first class of the new School of Nursing arrived - all eight of them. The first class graduated in 1957.

UAMC moved to the West Markham campus in 1956. Unfortunately, patient rooms were not air conditioned until 1966.

In 1957, federal loan funds were secured and construction began on a new student residence building and student union. Dr. Jeff Banks died that year, and the student union building was named in his honor. The Education Building I was completed, the first open heart surgery in Arkansas was performed by Dr. Masuki Hara at UAMC, and the Central High Crisis occurred.

In 1958, the School of Pharmacy moved to the Education Building I, an inpatient unit for adult psychiatric patients opened, and the School of Nursing became the first in Arkansas to be fully accredited by the NLN.

1960

In 1960, the Jeff Banks Student Union and Residence Building opened, Dr. Masuki Hara performed the first heart bypass operation, and the Arkansas Legislature authorized University Hospital to admit "full pay," or non-charity, patients.

In 1961, Colonel T.H. Barton, the Lutterloh Trust and the Buchanan Foundation donated funding, along with federal matching dollars, to construct the T.H. Barton Research Building. Finished that same year, the Barton Research Building became the first building on campus devoted solely to research. UAMSC acquired its first artificial kidney in 1961.

Bob Donaldson was hired in 1963 by Dr. Winston Shorey to develop "media" on the UAMSC campus. Between 1963 and 1980, approximately 500 motion pictures were created at UAMSC.
In 1964, the first kidney transplant in Arkansas was performed at UAMC by Drs. Masuki Hara and William Flanagin.

In 1965, the Arkansas legislature began funding "full pay" beds for University Hospital, which removed the hospital from the "charity" classification. The Education I building was renamed the Shorey Building, and an experimental program using closed circuit TV was initiated by the Departments of Hematology, Pathology and Pharmacology. The first Marines arrived at Da Nang, Vietnam; U.S. troops reached 200,000.

Distance learning advanced in 1966, when UAMSC began to use video tape in teaching, and in 1967, the School of Medicine was selected to participate in the Network for Continuing Medical Education, which duplicated programs produced on videotape by medical centers and distributed them to medical schools and hospitals nationwide.

In 1968, the Arkansas legislature authorized the School of Medicine's clinical faculty to accept fee-for-service patients, and to use that income to supplement individual faculty salaries. The million-dollar Child Study Center was created in 1969 and supported by legislature appropriations, contingency funds guaranteed by Governor Winthrop Rockefeller, monies transferred from the Arkansas State Hospital and matching federal funds from the Community Mental Health Centers Act.

1970

In 1970, the School of Health Related Professions was approved by the Board of Trustees, a new audio-visual library opened at UAMC, and color closed-circuit TV was first used at the university. In 1972, an atomic-powered pacemaker was implanted in the heart of a 22-year-old patient by Doyne Williams, M.D., the third surgeon in the United States licensed by the AEC to handle the investigative device.

In 1973, the Area Health Education Center (AHEC) program was established to provide health care and education throughout the state, and the UAMC clinical laboratories introduced a new computer system.

In 1974, construction began on the Education Building II, funded by over $20 million from the legislature and approved by Governor Dale Bumpers. The building included two large amphitheaters, classrooms, a three-level library and multi-media/audio-visual support units. The Arkansas Poison Control Center (the state's only poison control center) and the Drug Information Center were established in the School of Pharmacy in 1974.

Several historic name changes were made in 1975: the name of the campus changed to University of Arkansas Medical Sciences Campus, the executive officer's title changed to chancellor and all four schools became colleges. In addition, first years students were no longer required to live in the University Medical Center Dormitory.

In 1976, the Department of Pathology acquired the first Siemens Transmission Electron Microscope, which provided the first scanning, scanning transmission, and x-ray microanalysis capability in the country.

The Education Building II was completed in 1977, and a microwave disk was installed to provide two-way visual and audio communications between UAMSC and ACH.

In 1979, Harry P. Ward, M.D. was appointed as the second chancellor of UAMS. The UAMS Department of Pediatrics moved to Arkansas Children's Hospital, and many ACH physicians thus became a part of the UAMS faculty.

1980

In 1980, the Ambulatory Care Center was completed, and the name of the campus changed to the University of Arkansas for Medical Sciences. The first annual fund raising campaign for UAMS began.

In 1981, the Ambulatory Care Center was officially designated as the Isaac Folsom Clinic but later became the Outpatient Clinic. In that same year, the Education Building I was renamed the Winston K. Shorey Building.
expansion of the Jones Eye Institute, and construction was completed on a building that houses the new PET (Positron Emission Tomography) scanner and cyclotron. In 2005, a campus-wide expansion project was announced, and plans were set in motion to change the landscape of the UAMS campus over the next few years.
In 1983, the first honorary degrees were awarded for the first time in nearly 100 years. Storm Whaley, William Cobb, and Isadore Meschan were the first honorees.

In 1984, the UAMS Foundation Fund Board formed the Chancellor's Circle.

In 1985, University Hospital and ACH initiated University Careflight, which transported patients to University Hospital by ambulance after they were flown by helicopter to Rick's Armory. The Student Learning Center on the JBSU mezzanine, which included five IBM PC's and two Apple IIe computers, was open 24 hours a day.

In 1986, the Family Medical Center was completed, and the Women's Health Center opened at Freeway Medical Center.

In 1987, the UAMS Helipad officially opened. It was located at the north end of Education II, where the College of Public Health is now located.


In 1989, the Arkansas Cancer Research Center opened, starting a tradition of excellence in helping patients with cancer and their families for years to come. That same year, the kidney transplant program celebrated its 25th anniversary.

1990

In 1990, Outpatient Surgery opened, the UAMS Continuing Medical Education Outreach program began and the M.A.S.H Program went statewide at all six AHECs.

In 1991, the Rural Hospital Program was established, and the Internet was installed at UAMS. The Arkansas Heart Transplant Program was formed as a consortium between UAMS Medical Center, Arkansas Children's Hospital, and Baptist Medical Center. UAMS has Arkansas' only Level 1 Trauma Center. The State Health Department and UAMS purchased Freeway Medical Building, and the first Mini-Medical School was sponsored by the UAMS College of Medicine.

Arkansas’ first frozen embryo pregnancy was announced by the IVF program at UAMS Medical Center in 1992. Arkansas CARES was formed, and a new distance learning program was established, creating the Arkansas Nurses Education Network.

The Community Women's Clinic, a joint project of UAMS Medical Center, the Arkansas Department of Health and Pulaski County, officially opened in 1993 in the Pulaski County Health Unit. The Arkansas Genetics Program celebrated its tenth anniversary.

The campus saw an explosion of growth and development in 1994: the Harvey and Bernice Jones Eye Institute opened; ACRC expanded to eleven floors, the walkway between UAMS and the VA opened and the University Women's Health Center opened on the fourth floor of the Freeway Medical Building. In addition, the Rural Hospital Program was added to AHEC, which brought telemedicine to Arkansas through grants from the Arkansas Energy Office and the Federal Rural Electrification Administration.

In 1995, the UAMS Graduate School was granted independent status from the Graduate School at the University of Arkansas-Fayetteville, and the Education III Building was completed.

"Here’s to Your Health," the radio information show sponsored by UAMS, went on the air on KUAR-FM, and the Arkansas Heart Transplant Program team performed its 100th heart transplant.

In 1996, the Phase II expansion of the ACRC building
was completed, CHRP celebrated its 25th anniversary and the Outpatient Center expanded. UAMS Medical Center became the first Arkansas hospital to be named to the U.S. News & World Report list of "America's Best Hospitals."

In 1997, the Donald W. Reynolds Center on Aging opened, and the Harry P. Ward Tower was dedicated. The Biomedical Biotechnology Center established Arkansas BioVentures program, Arkansas' first biotechnology start-up company. On-line, Web-based distance learning began in the College of Nursing, and M. Gazi Yasargil, M.D., was named Neurosurgeon of the Century by the Congress of Neurological Surgeons.

In 1998, UAMS assumed responsibility for the Pulaski County Head Start Program, and the AHEC Program celebrated its 25th anniversary. The Society of the Double Helix was established to honor major donors and UAMS' Clinical Skills Center opened.

In 1999, Arkansas' only Gamma Knife Center opened at UAMS; ACRC celebrated its tenth anniversary; "Aging Successfully with Dr. David," starring Dr. David Lipschitz, began on AETN; and the Arkansas AHEC program was named the best in the nation by the National AHEC Organization. Dr. Milton Waner also held the first UAMS International Telemedicine consultation with a five-year-old patient and her doctors in Israel that year.

2000
The year 2000 ushered in a new century, a new millennium and new growth and change for UAMS. In 2000, I. Dodd Wilson, M.D., was appointed the third chancellor of UAMS. The Central Arkansas Radiation Therapy Institute (CARTI) and the was Donald W. Reynolds Center on Aging were completed, and a state-of-the-art Endoscopy Center and the General Clinical Research Center opened. University Hospital was named one of the 100 Most Wired hospitals and health systems by Hospitals and Health Networks, and Arkansas' first laparoscopic gastric bypass surgery was performed at UAMS.

In 2001, the establishment of the world's first Myeloma Institute for Research and Therapy was announced, and the College of Public Health was formed. The Alzheimer's Disease Center was founded in the Department of Geriatrics - one of only 29 such centers in the United States at the time.

The Russian-American Family Medicine Clinic opened in 2001 in Volgograd, Russia as a result of educational exchange between AHEC and the Volgograd Medical Academy. The Jones Eye Institute celebrated its tenth anniversary, and the College of Pharmacy celebrated its fiftieth anniversary in the same year.

Harry P. Ward, M.D., retired as chancellor at UAMS in 2001 and was succeeded by I. Dodd Wilson, M.D.

In 2003, the Jackson T. Stephens Spine and Neurosciences Institute, the new College of Public Health, the BioVentures building and the Biomedical Research Center II all opened. UAMS initiated collaborations to found The Clinton School of Public Service. Suzanne McCarthy became the first graduate of the College of Public Health.

In 2004, the College of Medicine celebrated its 125th anniversary. As part of the UAMS Get Healthy program, a new fitness center opened in the College of Public Health and began its first week with over 1000 members. As a part of the UAMS "Get Healthy" program, UAMS became one of the first medical centers in the country to adopt a campus-wide non-smoking policy. Later that year, the state's first liver transplant program began and plans were unveiled to build a major expansion of University Hospital.

Almost halfway through the first decade of the 2000s, construction began on an
Dr. I. Dodd Wilson is the Chancellor of the University of Arkansas for Medical Sciences in Little Rock. As the leader of this campus of the statewide University of Arkansas System, he directs the educational programs for professional degrees in many of the life sciences. The university is comprised of six major teaching units: the Colleges of Medicine, Pharmacy, Nursing, Health Related Professions, and Public Health; plus the Graduate School. The university is also known for the clinical programs within UAMS Medical Center, its $103-plus million dollar program of research and other grants, and its community service outreach projects throughout Arkansas.

He became the Chancellor in October 2000. He offered an ambitious eight-point program to guide the university into the 21st century, stabilized and then improved the university’s financial base, and adapted the administrative team to the program of work ahead for the state’s only comprehensive academic medical center. The university employs nearly 8,500 people and operates with a current annual budget of about $700 million – which is the largest campus budget in the University of Arkansas System.

Dr. Wilson previously served the university as Dean of the College of Medicine and UAMS Executive Vice Chancellor. During his tenure, the college enjoyed rapid growth in both the research and clinical enterprises. In 1995, Dean Wilson organized the first endowment for the college, the Founders Society, which now totals over $25 million with 300 contributing members. The National Institutes of Health ranks the college 68th in research funding to medical schools, up from a ranking of 100th in 1985. The success of the many new ventures of the college, including, for example, the Biomedical Biotechnology Center and the Arkansas Center for Health Improvement, reflect his commitment to excellence.

Dr. Wilson is past chair of the Council of Deans, Association of American Medical Colleges (AAMC) and served on its Executive Committee. He presently serves on the Board of Directors of the Association of Academic Health Centers.

Dr. Wilson came to UAMS in 1986 from the University of Minnesota Medical School where he was Vice Chairman of the Department of Medicine. He graduated from Dartmouth...
I. Dodd Wilson, M.D., Chancellor - University of Arkansas for Medical Sciences - Where Medicine Lives

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College and received his M.D. degree from Harvard Medical School.

He and his wife, Ginger, have three children: Matt, Kit, and Dan and four grandchildren

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The University of Arkansas for Medical Sciences: A Powerful Economic Engine for Arkansas

MAY 17, 2002 | Of the five major campuses in the University of Arkansas System, the University of Arkansas for Medical Sciences (UAMS), along with its affiliates, generates the largest economic impact – more than $1 billion in direct impact and more than $3 billion in indirect impact.

These figures are based on an economic impact analysis by the Institute for Economic Advancement at the University of Arkansas at Little Rock. UAMS, Arkansas’s only academic health center, trains physicians, nurses, pharmacists, scientists, and other health care professionals; provides inpatient and outpatient clinical care in a network of facilities; conducts scientific research; and delivers a wide variety of services around the state. (See more about statewide services.) UAMS is comprised of five colleges (health related professions, medicine, nursing, pharmacy, and public health), a graduate school that confers doctoral degrees in the basic sciences, a teaching hospital and clinics, including several world-renowned clinical programs, and a network of Area Health Education Centers (AHECs) around the state that provide health care and learning sites for young physicians receiving specialized training in family and community medicine. Most of the physicians at Arkansas Children’s Hospital and the Central Arkansas Veterans Healthcare System are actually faculty of the UAMS College of Medicine; those hospitals are affiliates of UAMS.

Although UAMS is a part of the state’s flagship university system, only 14 percent of its revenue comes from the state. The balance is income from health care services, external research...
funding, and payments for contracted services and programs. Contrary to popular belief, tuition is a very small portion of the university’s revenue: only about 2 percent.

As well as being essential health care providers in their communities, employees and graduates of UAMS are important as consumers, investors, and taxpayers. The institution’s payroll was more than $287 million in fiscal year 2001; employees paid more than $13.8 million in income taxes to the state and $80.8 million in income taxes to the federal government.

UAMS is the sole provider in the state of physicians, advanced practice nurses, nurse educators, and pharmacists. It is also a major provider of allied health professionals in 13 disciplines and research scientists in 12 fields. Because most health-care salaries are above the average, these stable, well-paying jobs boost local economies.

Current construction of needed additional space for patient care, teaching, and research is pumping another $93 million into the state’s economy, with some of the funds coming from the state’s share of the nationwide tobacco settlement and some from private philanthropy. (See more about current construction on the UAMS campus.)

UAMS’s research program has grown from $5.5 million in annual external funding in 1984 to more than $76 million this year. (See more about current research.) University researchers have obtained 70 patents for inventions or applications, with about 100 others pending. Researchers also have 28 license agreements, with some or all likely to generate additional economic activity in Arkansas, and to earn income for UAMS, in the future.

Services to the state are an important part of the UAMS mission. The university’s regional programs, including the Rural Hospital Program and the network of AHECs and satellite centers on aging, foster better health and health care across the state. Funding from the state’s share of the nationwide tobacco settlement has been critical in several of these areas, including establishment of the new College of Public Health, creation of a seventh AHEC in Helena to serve east Arkansas, and the Schmieding Center for Senior Health, Education Opens in Springdale.

Through its biomedical and biotechnological research programs, UAMS is creating new economic opportunity in Arkansas.

http://www.uams.edu/today/2002/051702/ecoimpact.htm
Arkansas, and support for the network of satellites of the Donald W. Reynolds Center on Aging.

Statewide Impact of the University of Arkansas for Medical Sciences in Arkansas
JUNE 2001

Links on This Page

Schmieding Center: http://www.uams.edu/today/2002/041102/schmieding.htm
Statewide services: http://www.uams.edu/today/NoBoundaries/default.htm
Current research: http://www.uams.edu/research/

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05/17/02
Introduction – Environmental Statement

The University of Arkansas for Medical Sciences (UAMS), Arkansas’s only academic health sciences center, educates most of the state’s health care professionals, including physicians, pharmacists, nurses and allied health professionals. UAMS provides high-level tertiary and quaternary patient care in the inpatient and outpatient facilities of University Medical Center; is committed to scientific discovery through research; and provides many outreach services and programs that directly benefit thousands of Arkansans each year.

Among the University’s many strengths are four outstanding patient care centers of excellence: the Arkansas Cancer Research Center that includes the Myeloma Institute for Research and Therapy, the Harvey and Bernice Jones Eye Institute, the Donald W. Reynolds Center on Aging, and the Jackson T. Stephens Spine and Neurosciences Institute. With world class clinical services, UAMS and its programs are in great demand. UAMS regional Area Health Education Centers (AHECs) combine with central resources to form one of the two best programs of its kind in the nation.

As part of a public university system, UAMS has always faced financial challenges because it operates with a greater underlying commitment to public service than its private sector counterparts. While the university does receive state assistance, historically the proportion is low compared to other state institutions. The current level of state financial support makes it difficult for the University to absorb major categories of expense, such as unreimbursed health care to indigent patients and academic programs for which costs far outweigh tuition. Creation of a new College of Public Health, new degree programs in response to state workforce needs, and the addition of another AHEC location (Helena), are examples of the University’s commitment to meeting the evolving needs of the state. These new programs and services also represent, however, additions to the lengthy list of financial and programmatic commitments shouldered by the University.

In planning to secure the long-term financial position of the University, its leaders are studying the feasibility of clinical expansion, since clinical revenue is by far the University’s greatest funding source. Current demand suggests that the Medical Center could increase revenue by increasing its capacity to treat both inpatients and outpatients. Despite completion of the Harry P. Ward Tower in 1999, the hospital’s core inpatient facilities are outmoded and not suited to renovation. Outpatient facilities are also no longer capable of meeting the demand for services, thus constraining patient volume and income.

In tandem with the need to expand (and incur added expenses), are plans to increase productivity, profitability and management of current resources. Responsibility-centered management (RCM) is being implemented to improve cost-responsive decision-making throughout the organization. Unit funding will be tied to total, actual costs, with executives and managers operating in a transparent fiscal framework. Federal dollars have been increased substantially over the biennium, with new sources of program support and grant funding providing key revenue enhancements. Additional sources of federal support have been identified and are expected to increase further over the next two years. A Comprehensive Campaign is also being planned to increase philanthropic and private support for UAMS’ primary missions over the coming decade. Strategic planning efforts include initiatives to increase federal research dollars, clinical trial income, and indirect cost recovery rates on federal grants.

The national and state economies are performing better, providing renewed optimism regarding the University’s financial outlook. Above-projected state revenues mean that there is little threat that the state funds UAMS does receive will be cut during this biennium. The improved national
economy suggests that support for existing programs can be obtained. However, the ever-rising cost of health care – which puts the cost of health insurance out of the reach of more and more Arkansans and Americans – remains the most critical issue for the foreseeable future.

UAMS continues to grow as a dynamic and respected institution. With a growing and more impressive work force across the state, the University is not only a major employer in Arkansas but also one with a positive and very substantial economic impact on the state’s economy. Drawing upon past growth and successes, the University begins the fiscal year with confidence that the challenges of the new year will be met with innovation, hard work and directed leadership.

Institutional Vision and Mission Statement

Vision Statement

UAMS will be a world class medical sciences center where excellence is the defining characteristic

Mission Statement

To Teach
The University of Arkansas for Medical Sciences prepares excellent health care professionals and scientists who are committed to high ethical and professional standards, life-long learning, and skill advancement in health care for Arkansas, the nation, and the world

To Heal
The University of Arkansas for Medical Sciences provides comprehensive, nationally and internationally recognized health care in many specialties and disciplines for Arkansas, the nation, and the world

To Search
The University of Arkansas for Medical Sciences conducts pioneering research that leads to new knowledge with application and integration into the health care disciplines, systems of care, public policy, and economic progress for all people

To Serve
The University of Arkansas for Medical Sciences provides leadership and service in the health care disciplines and in public health policy for the benefit of the citizens and communities of Arkansas
GOAL 1: EDUCATION

GOAL 1. TO EDUCATE EXCELLENT LEADERS, HEALTH CARE PROFESSIONALS, AND SCIENTISTS TO IMPROVE THE HEALTH OF THE CITIZENS OF ARKANSAS, THE NATION, AND THE WORLD

Objective 1. Strengthen the educational mission of UAMS, recognizing the interdependence of education with research and clinical care.

Strategies:
1. Convene conference(s) on strategic planning for education
2. Form a Deans Council to provide coordinated leadership for UAMS’ educational mission
3. Each college will maintain a system for recording and reporting academic information (student, courses/curriculum, and faculty), that is consistent and compatible with institutional reporting needs, including reports to federal and state governments and accreditation agencies

Objective 2. Identify and respond to Arkansas’ health workforce needs

Strategies:
1. Each college will develop an objective methodology (standards, sources, and plan of analysis) for determining demand for its graduates of both its current and proposed educational programs. Methodologies will include an explanation of known data issues, e.g., biased or skewed estimates, and may include existing resources such as AHEC’s biennial publication on the state’s Health Work Force needs
2. Colleges will conduct analyses of program and enrollment performance relative to established methodologies
3. Colleges will adapt programs, adjust enrollment levels in existing programs, and create new programs as indicated by the combined results of workforce and cost-benefit analyses

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1 Either one campus-wide conference, or a series of college-based conferences.
2 The Deans voted to maintain theDean’s Council membership as only the Deans and the Vice Chancellor for Academic Affairs/Research Administration, with special invitation to the Associate Deans and other guests as needed.
Objective 3. Recruit and retain productive faculty and staff for educational programs

Strategies:
1. Identify educational areas for expansion and development
2. Ensure that salaries of productive faculty and university leaders are competitive for the purpose of recruitment and retention
3. Identify and prioritize infrastructure needs (e.g., equipment, IT-related systems, space), necessary for the support of the educational mission

Objective 4. Increase enrollment and graduation rates of underrepresented and underprivileged students

Strategies:
1. Strengthen supportive pre-college and pre-admission programs that will serve as a source of underrepresented students
2. Consolidate pre-college student development programs to achieve greater synergy among the existing programs sponsored by various units
3. Improve promotion of creative programs both on campus and throughout the state that will foster interest in health care careers
4. Expose gifted and talented students who represent underrepresented demographic segments to experiences that will encourage them to choose a career in academic health sciences

Objective 5. Develop and utilize educational methodologies that are appropriate and cost-effective

Strategies:
1. The Office of Educational Development will coordinate a cross-college assessment of the feasibility of various educational methodologies and technologies employed at UAMS, as well as the infrastructure for implementing and maintaining those methodologies
2. Based on these evaluations, education leaders will formulate models to establish ideal education programs and support systems
3. Education leaders will prepare an action plan to implement the model’s provisions; program planning will take into account cost-effectiveness as well as cost-benefit margins
Objective 6. Ensure that appropriate recognition, support and career development is given to faculty for their educational activities

Strategies:
1. Ensure that faculty members are appropriately recognized for their teaching activities
2. Offer ongoing education workshops to all UAMS teaching faculty
3. Improve effectiveness of college-level teaching awards to faculty by coordinating recognition events, communication, and publicity for award winners: for example, each year all teaching award winners could be featured in a joint advertisement in the state newspaper\(^3\)
4. The Deans Council and VCAC will address how to create and fund a campus-wide intramural grant program to provide seed money for studies in education

Objective 7. Increase financial support for education [Related to Goal 5]

Strategies:
1. Create a strategic plan to increase the financial support for the educational mission of each college, including strategies for the Development Office, Legislative Affairs Office, etc.
2. Create a capital funding initiative for construction, maintenance and operation of facilities to support education throughout the state
3. Increase private gifts and endowments that will support UAMS' academic programs, personnel and support services, including the Library
4. Assuming approval, participate in the Campus Comprehensive Campaign, including all phases of study, planning and operations of such a campaign designed to raise funds for educational facilities, endowments and programs

\(^3\) The Chancellor will share support for this activity.
GOAL 2: CLINICAL PROGRAMS

GOAL 2. PROVIDE OUTSTANDING, PATIENT-CENTERED HEALTH CARE

Objective 1. Improve access to clinical care

Strategies:
1. Re-engineer outpatient programs to increase capacity to meet the needs of patients for access to patient care services.
2. Increase efficiencies within outpatient operations to achieve greater cost-effectiveness.
3. Implement mechanisms to ensure accountabilities, i.e., that the goals for outpatient productivity and cost effectiveness are attained.
4. Re-engineer admission/discharge processes to ensure adequate inpatient bed capacity. (Improve capacity management).

Objective 2. Develop and optimize clinical services

Strategies:
1. Establish components of a development plan for improving and expanding clinical programs
2. Define personal and unit-level accountability to ensure achievement of clinical program development goals.

Objective 3. Continuously improve the quality and safety of patient care.

Strategies:
1. Integrate and improve existing hospital and departmental quality-monitoring programs
2. Participate in appropriate external quality monitoring programs and implement plans to correct areas needing improved performance.
3. Maintain a Patient Safety Program that integrates all activities which contribute to the improvement and maintenance of patient safety, such as performance improvement, environmental safety and risk management. The goal is to reduce health care errors and proactively identify and correct potential risks that contribute to unexpected adverse patient outcomes.
4. Implement information systems that enhance the provision of high quality, safe patient care.
5. Plan and implement information systems that support the creation of an integrated computer-based medical record system
6. Strengthen the patient complaint process by linking follow-up directly to clinical programs management and decision-making, ensuring accountability for response and corrective action.
Objective 4. Improve the satisfaction of patients/families and referring health care providers

Strategies:
1. Develop a patient satisfaction plan that involves all caregivers of UAMS Medical Center and focuses on improvement areas identified by the surveys.
2. Conduct patient satisfaction surveys on the following schedule: inpatients (quarterly), outpatients (quarterly); Emergency Department patients (quarterly). The results will be used to set priorities for training and other corrective actions. The goal is to be above the Press Gainey mean score for other university hospitals.
3. Make regular visits to the offices of physicians and other health professionals who refer patients. Utilize feedback (surveys and office visits) from referring health providers to improve their relationship with UAMS Medical Center

Objective 5. Improve the financial performance of UAMS Medical Center to support the Strategic Financial Plan

Strategies:
1. Establish and monitor achievement of performance goals and benchmarks, including clinical growth targets by service line and cost efficiency targets for labor and supplies. These were set by the Kaufman Hall engagement to develop a strategic financial plan.
2. Target and execute key initiatives for cost improvement for clinical efficiency, labor costs and supply costs.
3. Design and implement Responsibility Centered Accounting and Reporting for UAMS Medical Center to ensure adequate budgeting for operations and capital identified in the Strategic Financial Plan.
4. Organize fund raising efforts to support capital needs

Objective 6. Implement the clinical facilities replacement/expansion plan

Strategies:
1. Explore opportunities for creating additional functional capacity within existing buildings (i.e., ALOS reductions, changes to hours of operation, etc.)
2. Complete planning to determine scope of clinical facilities development.
3. Complete Pre-Design for Inpatient facility including concept definition, operational programming, space programming and facility planning.
4. Complete architectural plans and construct inpatient facility.
5. Implement outpatient facilities plan as determined by the outpatient consultation engagement.
Objective 7. Recruit and retain the workforce necessary to accomplish the clinical goal and objectives in this plan

Strategies:
1. Maintain salaries at a competitive level
2. Develop a formal comprehensive compensation plan that provides financial incentives for performance
3. Develop and implement a rewards/incentive program for employees that focuses on the clinical objectives
4. Develop a more routine review of specific vacancy and turnover rates; implement actions to improve areas that are higher than the goals of the organization
5. Complete an employee survey every two years and use the findings to develop discrete work unit and organization work plans to improve areas identified as “High Importance and Low Performance”. The work plans will require quarterly follow-up progress reports.

Objective 8. Redefine the relationship between UAMS Medical Center and Arkansas Blue Cross and Blue Shield

Strategies:
1. Achieve access for UAMS Medical Center to the patient volumes represented by BCBS members
2. Re-negotiate the BCBS reimbursement structure
GOAL 3: RESEARCH

GOAL 3. MAKE EXCELLENCE IN RESEARCH A DEFINING CHARACTERISTIC OF UAMS

Objective 1. Double federal funding for research within five years

Strategies:
1. Increase aggregate funding of the present faculty by 25 percent
2. Recruit new funded and fundable faculty
3. Utilize research space to maximize productivity
4. Provide pilot study and bridging support that lead to extramural funding
5. Retain highly productive faculty by ensuring that their salaries match national benchmarks
6. Develop a business plan to evaluate the impact of increased research funding
7. Enhance the institutional research infrastructure (e.g. biometry, grants management, animal facilities, and the grant writing group) to support the planned expansion of research, including implementation of an information system that would allow accurate identification, tracking and analysis of issues related to research faculty
8. Plan coordinated improvements in research core facilities necessary to support research expansion
9. Collaborate with other Arkansas institutions on efforts to strengthen and promote research activities; e.g., National Center for Toxicological Research, other institutions of higher education, and appropriate state agencies such as ASTA

Objective 2. Develop all shelled space designated for research and expand research facilities

Strategies:
1. Successfully apply to the National Center for Research Resources for a matching grant for an animal management facility
2. Use campus and college reserves to complete shelled space as needed for new faculty recruitment for programmatic expansion
3. Obtain non-NIH federal support for programmatic expansion
4. Obtain philanthropic support for research programs

4 Chuck Winter and Al Reece have completed a business plan for the COM; and agree that it should be shared with the Research Council.
5 Must develop a system for evaluating need and scientific merit for shared resources. ACRC has developed a plan based on systems at other cancer centers. Need system for anticipating translational and clinical research needs. Core regulatory area is drastically understaffed.
Objective 3. **Achieve research objectives of selected colleges, centers and institutes within five years**

**Strategies:**
1. Prepare at least one successful NIH Center grant by the end of FY 06
2. Continue development of the four areas of research emphasis identified by the College of Nursing
3. Encourage the preparation of two large collaborative research grants among colleges by FY 06
4. Increase funded clinical trials by at least 50 percent
5. Develop nationally or internationally recognized collaborative research areas in at least 50 percent of the departments of the College of Medicine
6. Obtain more training grants

Objective 4. **Use appropriated tobacco settlement funds as one of the sources to double external funding for tobacco-related research**

**Strategies:**
1. Emphasize tobacco-related research (e.g., cancer, public health, cardiovascular and pediatric disease research)
2. Support successful current investigators with transitional funding to develop new areas of research that will lead to new grant support in tobacco-related research
3. Recruit new faculty to augment tobacco-related research

Objective 5. **Double the number of patent applications presented for review by the Screening Committee, and increase the number of BioVentures Companies to 25**

**Strategies:**
1. Complete the Arkansas Bioventures building and raise operational funds for subsidizing the early development of these companies
2. Strengthen the efforts of the Biomedical Biotechnology Center to facilitate disclosure of inventions, patent applications and retention, licensing, and company development

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6 Criteria for establishing a national or international area include publications, citations, recognition, etc.

7 Many believe that tobacco settlement dollars can fully support this goal. However, this cannot be the sole source.

8 Discussion: a pre-patent committee should look at the marketability of effectiveness of a potential patent. If an idea has economic future, then it should move on to the Patent Committee. Thus, just increasing the number of patents to 150 without economic potential is meaningless. There is significant cost associated with obtaining and maintaining a patent, and mechanisms to control that cost should be put in place. However, many faculty miss opportunities to obtain a viable patent because they do not recognize the opportunity for commercialization of an intellectual product.
Objective 6.  Maintain research compliance at levels that meet federal requirements regarding financial grants accounting, human volunteer safety, informed consent and privacy

Strategies:
1.  Meet HIPAA regulations with regard to privacy by adding necessary infrastructure and personnel
2.  Assure that UAMS meets all applicable federal regulations and accrediting body standards, especially those related to the welfare of human volunteers
3.  Develop funding formulae that will provide resources to key support offices that are proportionate to needs of the research community (e.g., grants accounting, IACUC, research compliance, and UAMS IRB)
4.  Continue development and expansion of ARIA, the research (protocol-based) information system, to include an additional clinical trials IRB panel, and to support increased access and functionality by various areas, such as ORSP and Grants Accounting

Objective 7.  Work with the CFO to maximize the indirect cost recovery rate of federal grants

Strategies:
1.  Conduct an inventory of current practices and processes
2.  Prepare an RFP for professional services to assist in developing a plan of corrective action
3.  Evaluate strengths and weaknesses of factors related to increasing the ICR -- including information and data systems
4.  Carry out a series of planned improvements necessary to support a rate increase
5.  Conduct negotiations to increase the rate, and implement revised rates as appropriate
GOAL 4: OUTREACH

GOAL 4. IMPROVE THE HEALTH OF ARKANSANS BY DELIVERING UAMS PROGRAMS AND SERVICES OFF-CAMPUS

Objective 1. Develop a comprehensive database for reporting UAMS outreach activities/programs

Strategies:
1. Utilize the UAMS Outreach Council to design a database survey instrument by August 31, 2004
2. Utilize the IT Department to write the online data collection program [10]
3. Support the institutional objective of establishing an Institutional Research Office that will manage the database and reporting functions
4. Initiate the development of a Website for outreach programs after the database has been tested and approved
5. Produce an annual comprehensive report of outreach programs and other reports as needed
6. Utilize the database to inform the public about outreach activities in their areas

Objective 2. Develop community partnerships that will enhance outreach delivery

Strategies:
1. Increase collaborative relationships between UAMS and other healthcare providers
2. Increase collaborative relationships between UAMS and non-healthcare partners

Objective 3. Offer more educational programs to students and health care professionals, as resources allow

Strategies:
1. Increase the number of courses for academic credit delivered off-campus
2. Increase the number of continuing education programs to meet the needs of health care professionals throughout the state

9 At the January 2004 Planning Retreat, the “Outreach” was defined as UAMS programs and services delivered off-campus.
10 To include continuing education activities.
Objective 4. Increase the number of programs related to lifestyle improvement that impact the citizens of Arkansas

Strategies:
1. Develop model community programs that demonstrate effective ways to inform and engage citizens in health improvement

Objective 5. Increase the number of graduates who choose to practice in underserved areas of the state

Strategies:
1. Increase available loan and scholarship funds for students committed to practicing in underserved areas
2. Increase off-campus educational opportunities for UAMS students in underserved areas
3. Implement more non-traditional methods of delivering educational programs to students in underserved areas
4. Increase levels of participation in, and effectiveness of, programs to prepare pre-college students for admission to UAMS colleges
5. Develop long-term partnerships with public schools, colleges and universities, and other organizations within underserved areas

Objective 6. Develop communication strategies that promote partnerships among health care and non-health care providers

Strategies:
1. Develop and implement a cohesive and consistent way of offering UAMS programs to all appropriate audiences
2. Maintain a Web presence that summarizes the various outreach activities and can be accessed through the primary UAMS Internet site
3. Promote outreach programs through ongoing media placements such as the Arkansas Broadcasters’ Association, the Arkansas Municipal League Magazine, and the Electric Cooperatives Magazine
4. Request that each AHEC director appoint a communications liaison for each AHEC area, so that information can flow accurately between the Office of Communications and Marketing
5. For marketing and public relations purposes, develop periodic reports which highlight outreach activities

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11 Will require collaboration with all colleges.
GOAL 5: SECURING THE FUTURE

GOAL 5. SECURE THE FUTURE OF UAMS BY INCREASING THE RESOURCES WE INVEST IN OUR MISSION

Objective 1. Develop and maintain an effective development program (John Blohm)

Strategies:
1. Conduct a comprehensive campus campaign
2. Build and manage an effective development program for ongoing support of the campus (beyond the campaign).
3. Establish guidelines that feature an ethical framework on how development activities are to be conducted effectively, and include the necessary coordination among campus units
4. Establish a process for implementing those standards across campus units and personnel
Objective 2: Recruit and retain the best people (Tom Butler)

1. Implement rewards, salaries and incentives for staff and faculty that are competitive with local and regional markets [Related to Goal 1, Objective 3]
2. Conduct periodic analyses to isolate problems, uncover inequities, and identify shifts which signal needed changes in policies and/or practices (such as benefits packages)  
3. Establish a campus-wide task force to recommend ways to establish a culture of excellence that will pervade the efforts of all UAMS faculty and staff
4. Address employee health and wellness issues through the UAMS Get Healthy programs and other initiatives
5. Establish mechanisms that seek input from employees across the campus on issues related to recruitment, retention and productivity
6. Strengthen support for activities that provide education and training for, and increase awareness of, multiculturalism and diversity issues

Objective 3. Expand all colleges and broaden our statewide presence, especially in Northwest Arkansas (Chancellor and Deans)

Strategies:
1. Increase enrollments of programs (where possible), including enrollment of out of state students [Related to Goal 1]
2. Explore academic program expansion opportunities with UA Fayetteville and other institutions of higher learning
3. Establish an emphasis on dispensary and patient education in the College of Pharmacy
4. Establish an emphasis on economic medicine, exploring financial partnerships with the business community, and educational collaborations with higher education institutions; e.g., UALR and UA Fayetteville Colleges of Business
5. Increase capacity for, and enrollment in, distance education-based courses for both traditional and continuing education programs

Objective 4. Improve the institution's financial decision-making capacity (Melanie Goodhand, Kari Cassel)

Strategies:
1. Understand our real operational costs in every major expense category
2. Look at opportunities to increase our margins, especially on major revenue streams
3. Implement Responsibility Centered Management/Budgeting
4. Implement and/or modify administrative and financial information systems to yield data needed by stakeholders at all levels (policy- and decision-makers, administrators, managers, analysts)

Routine examination of statistics such as turnover rates by area can indicate management and/or systemic problems; examination of demographic shifts can cue needed changes in pay, benefits, and incentives. For example, in the US more than 40% of the work force is not married. Corporate HR offices are re-examining benefits and incentive packages to make them more relevant to the single (non-married) worker.

To include all colleges and divisions of the University, and not just the Medical Center, which currently conducts scheduled surveys of its employees.
Objective 5. Engage in institutional capacity-building activities (Melanie Goodhand)

Strategies:
1. Implement eCommerce solutions as a customer payment method for major accounts, such as patient billing, student tuition and fees, and continuing education fees.¹⁴
2. Incorporate management and development roles within each functional area (clinical¹⁵, research, educational) that are dedicated to identifying potential new services, products and sources of revenue (e.g., new services to the aging population, etc.)
3. Establish effective incentives for good financial stewardship; e.g., a rewards program for money-saving or revenue-generating ideas; and programmatic mechanisms that recognize and reward desired behaviors: to save money, reduce costs, increase revenues and margins, build savings and reserve funds, and recycle or redistribute assets.

Objective 6. Implement the plan with authority and accountability behind it (Chancellor, Melanie Goodhand)

Strategies:
1. Identify specific persons/units responsible for implementing various objectives and strategies
2. Endow those persons/units with the authority necessary to stimulate action by others, and communicate this authority in a concrete way (that is clear and easily communicated)
3. Incorporate skills and performance objectives into job descriptions and job performance standards of appropriate leaders, managers, faculty and staff

¹⁴ eCommerce is currently being explored by the Academic Computing Advisory Committee for continuing education purposes.
¹⁵ Within the clinical structure, this role has been assigned to the Clinical Enterprise Committee.
Departments and Divisions

Office of the Chancellor

Academic Affairs and Research Administration
Research Administration
- Research and Sponsored Programs
- Academic Affairs
  - Institutional Review Board
  - Office of Research Compliance
- Library
- Educational Development
- Student Activities & Housing
- Academic Services
- Academic Computing

Administration and Governmental Affairs

- Human Resources
- Jobs at UAMS
- Employee Assistance Program
- Training Consortium

Campus Operations

- Bookstore
- Campus Housekeeping
- Clinical Engineering
- Construction and Contract Management
- Mail Services
- Nutrition Services
- Occupational Health & Safety
  - Occupational Health and Safety Training
- Parking Operations
- Physical Plant
- Police Department
- Real Estate Management
- Rental Properties and State Leases
- Telecommunications

Arkansas Cancer Research Center
Donald W. Reynolds Center on Aging
Harvey & Bernice Jones Eye Institute
Myeloma Institute for Research and Therapy
Jackson T. Stephens Spine and Neurosciences Institute

UAMS Medical Center

- Department of Pharmacy Services
- Business Development and Managed Care
- Clinical Housekeeping
- Clinical Programs Nursing Manual
- Clinical Staff Education Online
- Department of Nursing
- University Hospital Formulary
- University Hospital Policies and Procedures
- Patient and Healthcare Services Key Telephone Numbers

http://www.uams.edu/Departments/default.asp

11/1/2005
Arkansas Interstates leading into Little Rock:

Driving Directions
From Little Rock National Airport:
- Take Airport Road southwest to I- 440 West.
- Take Exit 138A to I- 30 East, towards downtown Little Rock.
- Take Exit 139B and merge onto I- 630 West.
- Take Exit 3B, keep right at the fork in the ramp, and turn right on Pine Street.
- Go north to Markham Street and turn left (west).
- Head west on Markham Street for 0.3 miles to 4301 West Markham Street.

From Memphis, Tennessee:
- Take I- 40 West.
- Take Exit 153B to I- 30 West towards downtown Little Rock.
- Take Exit 139B and merge onto I- 630 West.
- Take Exit 3B, keep right at the fork in the ramp, and turn right onto Pine Street.
- Go north to Markham Street and turn left (west).
- Head west on Markham Street for 0.3 miles to 4301 West Markham Street.

From Forth Smith, Arkansas:
- Take I-540 (US 71) to I-40 East, towards Little Rock.
- Take Exit 153B to the right, onto I-30.
- Take Exit 139B and merge onto I- 630 West.
- Take Exit 3B, keep right at the fork in the ramp, and turn right onto Pine Street.
- Go north to Markham Street and turn left (west).
- Head west on Markham Street for 0.3 miles to 4301 West Markham Street.

From Texarkana, Arkansas:
- Take I-30 East to Little Rock.
- Take Exit 129 to I-430 North.
- Take Exit 6 to I-630 East, towards downtown Little Rock.
- Take Exit 3B, keep right at the fork in the ramp, and turn right onto Pine Street.
- Go north to Markham Street and turn left (west).
- Head west on Markham Street for 0.3 miles to 4301 West Markham Street.

From West Little Rock
- Take I-630 East.
- Bear right on ramp at sign reading "Exit 4 Fair Park Blvd."
- Turn left on Fair Park Blvd and go Northeast.
- Turn right on West Markham Street and go East for 0.5 miles to 4301 West Markham Street.

University of Arkansas for Medical Sciences Campus with patient parking areas in yellow. Handicapped parking is provided at the curb near the entrance to Ward Tower on Hooper Drive and at convenient access points for most other UAMS buildings.
For your convenience, valet parking is available at the entry drive to the Arkansas Cancer Research Center, Outpatient Center, and Jones Eye Institute: ($3.00 charge)
University of Arkansas for Medical Sciences  
4301 W. Markham St., Little Rock, AR 72205

To Make an Appointment Call the Appointments Center at: 1-501-686-8000 or 1-800-942-8267
For Patient Information/Rooms, Call 1-501-686-6416
To Direct Dial a Patient Room, call 1-501-614-2 and the Room Number
For General Information and for Numbers Not Listed, Call 1-501-686-7000
For International Patient Appointments, Call 1-501-686-8071

For Information on Mailing or E-mailing UAMS Patients
Contact us with questions about the UAMS website.
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UAMS Frequently Asked Questions

Browse the FAQ - Click on the Browse the FAQ link to view questions and answers in UAMS' dynamic, database driven question and answer system. You may search for questions and answers by keywords you enter in the search field or expand and collapse individual sections to view questions that have been answered. You may also submit a question. We will work to answer the question as quickly and completely as possible.

Direct Links to FAQ Sections

- About Health Care for Patients
- For Visitors: Directions to and Around UAMS
- About Academic Enrollment in UAMS Colleges
- About the UAMS Mission
- For News and Information
- About Navigating and Using the UAMS Website

University of Arkansas for Medical Sciences
4301 W. Markham St., Little Rock, AR 72205

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For International Patient Appointments, Call 1-501-686-8071

For Information on Mailing or E-mailing UAMS Patients

Contact us with questions about the UAMS website.

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Faculty Resources

C. UA Board of Trustees Policies

1. Selected Policies Governing Faculty Service

Addition, Deletion, Suspension and Modification of Academic Programs (Board Policy 620.1)

Appointments, Promotion, Tenure, Non-Reappointment, and Dismissal of Faculty (Board Policy 405.1)

Authorization to Offset Amounts Due University (Board Policy 405.2)

Contracting Authority (Board Policy 300.1)

Emeritus Status (Board Policy 475.1)

Employment Periods (Board Policy 405.4)

Nepotism (Board Policy 410.1)

Outside Employment of Faculty for Compensation (Board Policy 450.1)

Patents and Copyrights (Board Policy 210.1)

Political Activity (Board Policy 465.1)

Promotion and Tenure Policies (College of Medicine)

Resignations of Employment (Board Policy 405.3)

Retirement Age (Board Policy 425.4)

Retrenchment and Academic Planning Retrenchment (Board Policy 405.5)

University of Arkansas Retirement Program (Board Policy 425.5)

The complete listing of University of Arkansas Board of Trustee Policy Statements may be found at http://www.uark.edu/admin/vcfainfo/botpolicies/.

Back

10/13/2005
ADDUCTION, DELETEUON, SUSPENSION, AND MODIFICATION OF ACADEMIC PROGRAlfS

The approval of the Board of Trustees is required for the addition, deletion, suspension, or significant modification\(^1\) of academic programs.\(^2\) The Board of Trustees reserves the right to delete programs because of low demand, low productivity, a modification of the role and scope of the campus, or financial exigency (as defined in Board Policy 405.5), or upon the initiative of the President, regardless of a recommendation for such action by the campus. In all such instances, however, the Board shall solicit comments and suggestions from the appropriate campus-wide governance body or bodies, from the Chancellor, and from the President before a decision is made.

Guidelines for proposing new academic programs shall be developed by each campus and approved by the campus governance body, chief academic officer, and Chancellor and submitted to the President. Such guidelines for proposing new academic programs must provide for review of proposed programs by the program or departmental faculty, college, school, or other sub-unit in which the program will be given, the campus governance body, the chief academic officer, and the Chancellor. If the Chancellor approves a proposal, it shall be forwarded to the President, who will report the results of the campus deliberation, along with his/her own recommendations, to the Board of Trustees for action. If the Chancellor disapproves the proposal, it shall be returned to the campus governance body, and further action will be subject to existing policies and procedures.

Two types of review shall be required for all established academic programs:

1. review of annual report of low productivity programs originating in the office of the chief academic officer of the campus, and
2. a periodic substantive evaluation of each academic program on a rotating schedule not to exceed ten years.

For the evaluations, each campus shall establish guidelines and criteria which shall be approved by the campus governing body, chief academic officer, and Chancellor and shall be submitted to the President. A recommendation for deletion, suspension, or significant expansion or modification of any program made as a result of either type of review shall be reviewed by the faculty of the program involved, the administrative head of the college, school, or other unit in which the program is located, the campus governing body, the chief academic officer, and the Chancellor. The Chancellor will forward his/her recommendations, along with those of the previous reviewing bodies, to the President who will report the results of the campus deliberation along with his/her own recommendations to the Board of Trustees for action.

\(^1\) A net change of more than fifteen credit hours in any twelve-month period.

\(^2\) An academic program is a curriculum leading to a certificate, associate degree, baccalaureate degree, specialist degree, or graduate degree.
January 31, 2003 (Revised)
September 14, 1984 (Revised)
February 18, 1983
APPOINTMENTS, PROMOTION, TENURE, NON-RE-APPOINTMENT, AND DISMISSAL OF FACULTY

This policy, adopted by the Board of Trustees on February 8, 1980, to become effective on July 1, 1980, supersedes all existing policies concerning appointments, promotion, tenure, non-reappointment, and dismissal of faculty (specifically, Administrative Memorandum No. 43, dated August 31, 1962; Universitywide Administrative Memorandum 421.1, dated December 6, 1976; Universitywide Administrative Memorandum 450.1, dated November 17, 1975; and Board Policy 405.1, dated September 1, 1962, and revised). Nevertheless, an employee of the University of Arkansas who held the rank of instructor prior to the effective date of this policy is eligible for tenure in accordance with Section II.A.(1-4) of Board Policy 405.1 dated September 1, 1962, and revised. The Board of Trustees has the right to amend any portion of this policy at any time in the future.

Copies of this statement of policies shall be kept by the dean of each college or school and by each department head or chairperson or other appropriate official and shall be included without change or inter-lineation in the Faculty Handbook for each campus. Care shall be taken to insure that each faculty member is familiar with its contents, and the department chairperson or other appropriate official shall supply a copy to each new member.

I. Definition of Terms

For purposes of this policy, the following definitions shall apply:

Appointment - An appointment is employment by written contract ("Notice of Appointment") by the Board of Trustees of an individual in a given capacity for a specified time period at a stated salary. An appointment is valid only when the appointment form is approved and signed by the President of the University or the President's designee in accordance with authority delegated by the Board of Trustees, and the Notice of Appointment is signed by the individual being appointed and returned to the specified University official.

Dismissal - Dismissal is severance from employment for cause after administrative due process as specified in Section IV-C. Non-reappointment is not a dismissal (see further).

Faculty - Faculty are employees who hold academic rank of lecturer, master lecturer, assistant instructor, instructor, assistant professor, associate professor, professor, distinguished professor, University professor, or one of the above titles modified by clinical, research, adjunct, visiting, executive in residence, or emeritus, e.g., clinical professor, adjunct assistant professor.

Individuals holding the following non-teaching titles will also receive faculty rank, the highest rank for each title being as indicated. Both the title and the academic rank will be stated in the appointment.

<p>| Instructional and Cooperative Extension Instructional | | | |</p>
<table>
<thead>
<tr>
<th>Research Ranks</th>
<th>Library</th>
<th>Service*</th>
<th>Development</th>
<th>Museum</th>
</tr>
</thead>
<tbody>
<tr>
<td>University Professor,</td>
<td>Director of Libraries,</td>
<td>Extension Specialist IV</td>
<td>Instructional Development</td>
<td>Curator</td>
</tr>
<tr>
<td>Distinguished Professor,</td>
<td>Librarian</td>
<td></td>
<td>Specialist II</td>
<td></td>
</tr>
<tr>
<td>Professor, Professor</td>
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<tr>
<td>Associate Professor</td>
<td>Associate Librarian</td>
<td>Extension Specialist III</td>
<td>Instructional Development</td>
<td>Associate Curator</td>
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<td>Specialist I</td>
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</tr>
<tr>
<td>Assistant Professor</td>
<td>Assistant Librarian</td>
<td>Extension Specialist II</td>
<td></td>
<td>Assistant Curator</td>
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<tr>
<td>Instructor</td>
<td></td>
<td>Extension Specialist I</td>
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</tr>
</tbody>
</table>

*Academic rank will be granted only if the individual is appointed in an academic unit.

**Non-Reappointment** - Non-reappointment means that a non-tenured faculty member is not offered a next successive contract for employment at the end of a stated appointment period. It is effected by a written notice sent in compliance with the time limits hereafter specified (IV.B.).

**Probationary Period** - The probationary period is the time a faculty member spends under appointments for full-time services in a tenure-track position on one campus of the University of Arkansas prior to being awarded tenure.

**Promotion** - Promotion is advancement based on merit to a higher rank or title. All promotions must be approved by the Board of Trustees and become effective with the next year's appointment following action of the Board of Trustees, unless a different effective date is approved by the Board for a specific case.

**Resignation** - Resignation is voluntary termination of employment by an employee. The dean or director of the unit to which the employee is assigned is authorized by the Board of Trustees to accept the resignation.

**Suspension** - Suspension is temporarily relieving an employee of duties.

**Tenure** - Tenure is the right of continuous appointment. It is awarded by the President to eligible members of the faculty upon successful completion by each of a probationary period and, once granted, it ceases to exist only by dismissal for cause according to the procedures in Section IV.C., demonstrably *bona fide* financial exigency, reduction or elimination of programs, retirement, or resignation. "Cause" is defined as conduct which demonstrates that the faculty member lacks the ability or willingness to perform his or her duties or to fulfill his or her responsibilities to the University; examples of such conduct include (but are not limited to) incompetence, neglect of duty, intellectual dishonesty, and moral turpitude. The probation
period may be waived as provided in Section IV.A.4. NOTE: Tenured faculty holding positions eliminated by reduction or elimination of programs will be relocated in other academic units of the campus whenever possible. A position occupied by a tenured faculty member which was eliminated as a result of reduction or elimination of a program may not be reactivated for a period of five academic years.

Tenure-Track Positions - Tenure-track positions are ranks of assistant professor, associate professor, professor, distinguished professor, and University professor. Faculty appointed to clinical attending positions at the University of Arkansas for Medical Sciences, or other non-tenure-track positions approved by the President, may bear the designation of assistant professor, associate professor or professor but in no event shall be considered in tenure-track positions and shall acquire no tenure rights by virtue of occupying such positions. Such non-tenure track positions shall be set forth in applicable promotion and tenure policies approved by the President which may authorize term appointments beyond one year.

Terminal Appointment - A terminal appointment is a final appointment, the expiration of which results in termination of an individual's employment.

Termination - Termination is the general term to describe severance of employment from the University. Termination may be by resignation, retirement, dismissal, non-reappointment, or expiration of appointment.

Year - Year will be either a fiscal year (July 1 through June 30 next) or an academic year (fall and spring semesters of the same fiscal year), unless otherwise designated.

II. Appointments

The following principles shall apply to appointments to faculty positions:

A. General

Appointments shall be for a specified period of time not to exceed one fiscal year. Except for appointments to faculty positions for summer school, appointments shall not extend beyond the end of a fiscal year.

Recommendations for appointments to the faculty will be made by the departmental chairperson after consultation with the departmental faculty concerned, and subject to the approval of the dean, chief academic officer, and chief executive officer of the campus, who alone shall make the final recommendation for appointment. (See definition of appointment, Page 1.)

B. Initial Appointment
Criteria and procedures for the initial appointment of all faculty members on a campus shall be adopted by the faculty of that campus through its governance structure; the deans and chief academic officer of the campus shall have an opportunity to give their advice regarding these criteria and procedures; these criteria and procedures must be submitted to the Chancellor of the campus and the President for approval. More detailed criteria and procedures may be adopted by the faculty and chairperson1 of each academic unit; these criteria and procedures must be submitted to the dean, the chief academic officer of the campus, the Chancellor of the campus, and the President for approval.

An appropriate degree or professional experience is an essential qualification for appointment to positions at academic ranks.

Other important qualifications include experience in teaching, research, or other creative activity, and educational service either at other colleges and universities and/or in non-academic settings.

C. **Successive Appointments**

Tenured faculty members have a right to a next successive appointment except for the reasons for termination of a tenured appointment given in Section I under definition of tenure. Non-tenured faculty do not have a right to a next successive appointment, but may be offered an appointment after the expiration of a current appointment, provided it does not extend the time in probationary status beyond the limits set in Sections IV.A.4 and IV.A.11. In the event that a non-tenured faculty member is not recommended for reappointment, the procedure described in Section IV.B. shall be followed.

Criteria and procedures for successive appointments of all faculty members on a campus shall be adopted by the faculty of that campus through its governance structure; the deans and chief academic officer of the campus shall have an opportunity to give their advice regarding these criteria and procedures; these criteria and procedures must be submitted to the Chancellor of the campus and the President for approval. More detailed criteria and procedures may be adopted by the faculty and chairperson of each academic unit; these criteria and procedures must be submitted to the dean, the chief academic officer of the campus, the Chancellor of the campus, and the President for approval.

III. **Promotion**

Promotion in academic rank shall be based primarily on the accomplishments of the individual while in the most recent rank. No minimum time in rank is required before a faculty member is

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1For the purpose of this policy, and in reference to items involving professional librarians, extension specialists, instructional development specialists, or museum curators the terms "chairperson," "administrative officer," and "administrator" refer to the director or head librarian.
eligible for promotion, nor is there a maximum time an individual may remain in a given rank except as limited by Sections IV.A.4. and IV.A.11. However, individual accomplishments and potential for continued value to the University are required for promotion.

Recommendations for promotion shall originate with the chairperson, who shall inform the faculty members who are being considered for promotion and shall give them the opportunity to submit material which they believe will facilitate consideration of their competence and performance. Each campus shall provide for the inclusion of peer evaluation in the consideration of faculty nominated for promotion.

Criteria and procedures for promotion to each rank on a campus, including an appeals procedure for those desiring reconsideration of a negative recommendation, shall be adopted by the faculty of that campus through its governance structure; the deans and chief academic officer of the campus shall have an opportunity to give their advice regarding these criteria and procedures; these criteria and procedures must be submitted to the Chancellor of the campus and the President for approval. More detailed criteria and procedures may be adopted by the faculty and chairperson of each academic unit; these criteria and procedures must be submitted to the dean, the chief academic officer of the campus, the Chancellor of the campus, and the President for approval.

IV. Tenure, Non-reappointment, and Dismissal

A. Tenure

1. The granting of tenure implies that the individual has completed successfully his or her probationary period and has become a permanent member of the University community. As such, he or she acquires additional procedural rights in the event that dismissal proceedings may be brought against him or her.

2. Only full-time faculty with ranks of assistant professor, associate professor, professor, distinguished professor, and University professor are eligible to be awarded tenure. Faculty and other employees with the following titles are ineligible to be awarded tenure: clinical, research, adjunct, visiting, or executive in residence faculty, research associates or research assistants, graduate associates or graduate assistants, instructors, assistant instructors, and lecturers. Faculty appointed to clinical attending positions at the University of Arkansas for Medical Sciences, or other non-tenure track positions approved by the President, although designated assistant professor, associate professor or professor, are ineligible to be awarded tenure. Academic administrators not appointed to a teaching or research unit may be awarded academic rank in addition to their administrative titles, with the concurrence of the faculty and administrative officer of the academic unit in which such rank could lead to tenure, in which case they may acquire tenure as faculty, but not as administrators. Other administrators and staff whose primary duties do not involve teaching regularly scheduled credit-hour courses, but who occasionally teach courses
are not eligible for tenure and do not acquire credit for service toward tenure for such teaching activities.

3. Tenure rights apply to the area or areas of the faculty member’s expertise and in the academic unit(s) in which his or her position is budgeted (examples: Department of English, UAF; College of Arts and Sciences; School of Law, UALR; Library, UAM; Departments of Music and Education, UAPB). Tenure rights are confined to a particular campus and are not applicable on another campus of the University of Arkansas.

4. The probationary period may not extend beyond seven years, except as specifically provided herein. An initial appointment of one-half year (academic or fiscal) or less will not be included in the probationary period. If more than one-half of any year is spent in leave of absence without pay status, that year shall not apply toward the probationary period.

During the first six years of the probationary period, a tenure-track faculty member may request, for reasons set forth below, that the probationary period be suspended by one (1) year. The reasons for such a request are the same as required under the Family and Medical Leave Act of 1993 and are as follows: (a) the birth of a child to the faculty member or his spouse and its care during the first year; (b) the adoption of a child by the faculty member or placement in the faculty member’s home of a foster child; (c) the care of the faculty member’s spouse, child, or parent with a serious health condition; (d) the serious health condition of the faculty member.

A request to suspend the probationary period for these reasons shall first be directed in writing to the department chair for approval and must also be approved by the dean (or approved through other established administrative channels), the vice chancellor for academic affairs, the chancellor, and the president, under such procedures as the president shall approve. These procedures may include, but shall not be limited to, the manner in which the faculty member’s duties and salary, if any, are determined during such year, the information which is required to substantiate a request and the extent to which a faculty member’s performance during such year may be considered in awarding tenure. A faculty member who has been notified that he or she will not be reappointed may not subsequently request to suspend the probationary period under this policy.

Upon the recommendation of the department chair, after consultation with the departmental faculty and with concurrence of the dean, the vice chancellor for academic affairs, and the chancellor, new appointees at the rank of associate professor, professor, distinguished professor, or university professor may be granted immediate tenure.
5. Recommendations for tenure shall originate with the chairpersons, who shall inform the faculty members in tenure-track positions who are being considered for tenure and shall give them the opportunity to submit material which they believe will facilitate consideration of their accomplishments and potential.

6. Criteria and procedures concerning the awarding of tenure on a campus, including an appeals procedure for those desiring reconsideration of a negative recommendation, shall be adopted by the faculty of that campus through its governance structure; the deans and chief academic officer of the campus shall have an opportunity to give their advice regarding these criteria and procedures; these criteria and procedures must be submitted to the Chancellor of the campus and the President for approval. More detailed criteria and procedures may be adopted by the faculty and chairperson of each academic unit; these criteria and procedures must be submitted to the dean, the chief academic officer of the campus, the Chancellor of the campus, and the President for approval.

7. The President will not consider awarding tenure to a faculty member in a probationary status without the prior recommendation of the faculty member’s departmental faculty, chairperson, dean, chief academic officer, and the chief executive officer of the campus concerned.

8. A faculty or staff member, on acquiring tenure rights, shall receive a notice from the chief executive officer of the campus affirming the acquisition of such rights. No person shall lose tenure rights by acceptance of leave-of-absence or by appointment to a University of Arkansas administrative position.

9. Tenure becomes effective at the beginning of the nine- or twelve-month appointment period following the President's action granting tenure (July 1 for twelve-month appointments, and the beginning of fall semester for nine-month appointments).

10. Each year at the meeting at which promotions are considered by the Board of Trustees, the President shall inform the Board of the names of each person awarded tenure during the preceding twelve months, and shall indicate for each such individual the rank and date of appointment to the University faculty.

11. An individual in a tenure-track position who was not awarded tenure with any of the first six academic year or fiscal year appointments must be evaluated as specified in Section IV.A.6 during the sixth appointment. If he or she is not approved for tenure, the seventh appointment shall be a terminal appointment.

12. A faculty or staff member holding tenure rights may be dismissed for cause only after the procedures prescribed in Section V.C. have been followed. A tenured person notified that he or she will be so dismissed will, except in cases of moral turpitude, be given notice of dismissal twelve months prior to termination of employment. This
provision does not create an award of severance pay, but assumes the full performance of University responsibilities and duties assigned for the period between dismissal notice and final termination.

13. No faculty member shall be dismissed or denied reappointment in violation of the following principles of academic freedom, but the observation of the limitations stated herein is the responsibility of each faculty or staff member. Mere expressions of opinions, however vehemently expressed and however controversial such opinions may be, shall not constitute cause for dismissal. The threat of dismissal will not be used to restrain faculty members in their exercise of academic freedom or constitutional rights.

a. The faculty member is entitled to full freedom in research and in the publication of results, subject to the performance of his or her other academic duties, but personal research for pecuniary return requires prior approval by the appropriate University authorities and must be in accordance with Board Policy 450.1.

b. The faculty member is entitled to freedom in the classroom in discussing the subject of the course, but should not teach material inappropriate or unrelated to the course.

c. The University faculty member is a citizen, a member of a learned profession, and a member of an educational community. Speaking or writing as a citizen, the faculty member is free from institutional censorship or discipline. However, as a person of learning and as a member of an educational community, the faculty member has a responsibility for awareness that the public may judge the profession and the institution by his or her utterances. Hence, faculty should at all times make an effort to be accurate, exercise good judgment and appropriate restraint, show respect for the opinions of others, and indicate that they are not spokespersons for the institution.

B. Non-Reappointment

These procedures apply to non-tenured faculty members who are in tenure-track positions (assistant professors, associate professors, professors, distinguished professors, and University professors) who are not offered a next successive appointment for the period following the expiration of a current appointment. These procedures do not apply to faculty in clinical attending positions at the University of Arkansas for Medical Sciences bearing the designation of assistant professor, associate professor or professor.

The appointment of a non-tenured faculty member may be terminated effective at the end of the appointment period, at the option of either the individual or the University.
A chairperson, dean, or chief academic officer who decides not to recommend a non-tenured faculty member for reappointment shall notify him or her in writing in accordance with the following schedule and shall enclose a copy of this section with the letter of non-reappointment:

Not later than March 1 of the first year of service, if the appointment expires at the end of that year; or at least three months in advance of its termination if the appointment terminates during the first calendar year of continuous employment.

Not later than December 15 of the second year of service, if the appointment expires at the end of that year; or at least six months in advance of its termination if an appointment terminates during the second calendar year of continuous employment.

At least twelve months before the expiration of the terminal appointment after two or more consecutive academic, fiscal, or calendar years in the institution. The terminal appointment will be for the academic or fiscal year, according to the appointment last held by the individual.

The individual, upon being notified that he or she will not be reappointed, may request an interview within ten working days after receipt of the notice, first with the dean of the school or college, or other appropriate administrators, then, if the employee requests it, within an additional five working days, with the chief academic officer of the campus. The dean of the school or college, or other administrator, and the chief academic officer jointly will, within ten working days, make the final decision on any request that the decision be reconsidered.

Department chairpersons and other employees of that campus may be requested to participate in their individual capacities in the interviews by the individual concerned, by the chief academic officer, or by the dean or other appropriate administrator.

If the individual does not request these interviews within the time limits stated above after receipt of notification of non-reappointment, the matter shall be considered closed.

C. **Dismissal**

This section applies to all faculty members.

1. **Preliminary Proceedings**

When a chairperson or dean has reason to consider a decision to dismiss a person who has tenure rights or an untenured faculty member prior to the expiration of an appointment, he or she shall discuss the matter with that person privately. After the discussion, if the decision of the chairperson or dean is to recommend dismissal, he or she shall prepare a statement of the grounds constituting the cause for dismissal and
forward it through the chief academic officer to the chief executive officer on the campus, with a copy to the faculty member. If the faculty member requests it within five working days after receipt of the statement, a subcommittee of faculty members, as determined by procedures developed by each campus, shall be named by the chief executive officer to make an informal inquiry into the situation and to effect an adjustment, if possible. If no settlement is effected, the subcommittee shall determine whether, in its view, formal proceedings shall be instituted to consider the individual's dismissal, and it shall notify the individual concerned, the chief executive officer of the campus, and other appropriate administrators of its conclusion. If the subcommittee recommends that such proceedings be begun, or if the chief executive officer of the campus, after considering a recommendation of the subcommittee favorable to the individual, decides that a proceeding should be undertaken, action shall be commenced according to the procedures which follow.

2. Hearing Procedures

The formal proceedings shall be initiated by a communication addressed to the individual by the chief executive officer of the campus informing him or her of the dismissal and the grounds for it, and that, if he or she so requests, a hearing to recommend whether his or her employment by the University shall be terminated on the grounds stated, will be conducted at a specified time and place by a faculty committee constituted as described in Section 4 below. Sufficient time shall be allowed to permit the individual to prepare a defense. The individual shall be informed in detail, or by reference to published regulations, of the procedural rights to which he or she is entitled, including the right to advice of counsel.

The individual shall indicate whether he or she wishes a hearing and, if so, shall file with the chief executive officer of the campus within two weeks of the date of the mailing of the communication by the chief executive officer of the campus an answer to the statement of grounds for the proposed dismissal.

If the individual does not request a hearing, no further action shall be taken. Further, at the request of the individual the proceedings provided for herein may be terminated at any time after the request for a hearing on written notice to the chief executive officer of the employee's acquiescence in the dismissal. Similarly, the administration may drop dismissal proceedings at any stage.

3. Suspension

Suspension of the individual from normal duties or reassignment to other duties during the proceedings will occur only if an emergency exists which threatens harm to the individual, to others, or to the University. Determination of an emergency shall be made by the chief executive officer, in consultation with the President. Such suspension shall be with pay.
4. **Hearing Committee**

The faculty of each campus shall establish a systematically rotated panel of faculty from which hearing committees can be drawn. To hear a particular case a committee, selected from the panel in accordance with campus policies, shall be composed of faculty members of departments not involved in the dismissal.

Upon receipt from the chief executive officer of the campus of a copy of the statement of grounds for dismissal, accompanied by the individual's answer thereto, the chairperson of the hearing committee shall conduct hearings and recommend a course of action as provided in Section IV.C.5.

5. **Committee Proceedings**

The committee shall proceed by considering, before the time of the hearing, the statement of grounds for dismissal already formulated and the individual's written response.

In addition to the members of the committee, only the person requesting the hearing and his or her representative, the chief executive officer of the campus and/or his or her designee, and witnesses called by the committee are permitted to attend the hearing.

Charges contained in the initially formulated statement of grounds for dismissal may be supplemented at the hearing by evidence of new events occurring after the initial communication to the individual which constitute new or additional cause for dismissal. If such supplementary charges are adduced, the committee shall provide the individual with sufficient time to prepare his or her defense.

The chief executive officer of the campus shall have the option to attend or not to attend the hearing, and he or she may designate an appropriate representative to assist in developing and presenting the case.

The committee shall determine the order of proof and shall supervise the questioning of witnesses.

The individual shall have the aid of the committee when needed in securing the attendance of witnesses. The individual or his or her representative and the chief executive officer of the campus or his or her designated representative shall have the right within reasonable limits to question all witnesses who testify orally.

The committee will use its best efforts to provide an opportunity for those involved to confront all witnesses, but where this cannot be achieved despite the efforts of the
hearing committee, the identity of such non-appearing witnesses, and any written
evidence they may have furnished, shall be disclosed to all interested parties during
the hearing.

Subject to these safeguards, written statements may, when necessary, be taken
outside the hearing and reported to it. All of the evidence shall be duly recorded.
Formal rules of court procedure need not be followed, but the committee shall
exercise reasonable efforts to protect the rights of the parties in the reception of
evidence.

6. Consideration by Hearing Committee

The committee shall formulate its recommendation in private, on the basis of the
hearing. Before doing so, it shall give opportunity to the individual and the chief
executive officer of the campus or his or her designated representative to make oral
statements before it. If written arguments are desired, the committee may request
them. The committee shall proceed to arrive at its recommendation promptly without
having the record of the hearing transcribed when it feels that a just decision can be
reached by this means; or it may await the availability of a transcript of the hearing. It
shall make explicit findings with respect to each of the grounds for removal presented.

The chief executive officer of the campus and the individual shall be notified of the
recommendation in writing and a copy of the record of the hearing shall be available
to both parties.

A copy of the record of the hearing and the recommendations of the hearing
committee shall be furnished to the President of the University for his or her decision.
The decision of the President shall be transmitted to the chief executive officer of the
campus and to the individual involved.

7. Consideration by Board of Trustees

If the decision of the President is appealed to the Board of Trustees, or if the Board
of Trustees chooses to review the case, the President shall transmit to the Board of
Trustees the full report of the hearing committee, stating its recommendation and his
or her own decision. The review shall be based on the record of the previous
hearing, accompanied by opportunity for argument, oral or written or both, by the
principals at the hearing or by their representatives. The decision of the Board of
Trustees on review shall be final. It shall be communicated to the President and
through him or her to the person involved.

V. Annual Review
An annual review of the work and status of each tenured and tenure-track faculty member shall be made on the basis of assigned duties and according to criteria and procedures required herein. Faculty not in tenure-track positions shall be evaluated by procedures adopted by each campus.

A. Faculty

The annual review of each faculty member shall provide the primary basis for the chairperson's recommendations relating to salary, promotion, granting of tenure, successive appointment, non-reappointment, and dismissal. Furthermore, this review is to provide guidance and assistance to all faculty in their professional development and academic responsibilities in the areas of teaching, scholarly and creative activity, and service.

Criteria and procedures for an annual review of all tenured and tenure-track faculty on a campus shall be adopted by the faculty of that campus through its governance structure; the deans and chief academic officer of the campus shall have an opportunity to give their advice regarding these criteria and procedures; these criteria and procedures must be submitted to the Chancellor of the campus and the President for approval. More detailed criteria and procedures may be recommended by the faculty and chairperson of each academic unit; these criteria and procedures must be submitted to the dean, the chief academic officer of the campus, the Chancellor of the campus, and the President for approval. All procedures for annual reviews adopted by a campus shall include provision for and details for implementation of the following:

1. Within a reasonable time after the beginning of the first appointment of each faculty member: written notification to the faculty member of the criteria, procedures, and instruments currently in use in assessing performance;

2. Within a reasonable time after the beginning of each academic year: written notification to each faculty member of that year's assignments, review schedule, and the criteria, procedures, and instruments to be used that year;

3. Reasonable opportunity for each faculty member to submit any material desired to be considered in the annual review;

4. Peer evaluation;

5. Student evaluation of teaching;

6. Prior to the chairperson's making a recommendation in any year: (a) a meeting between the chairperson and faculty member to discuss all issues relating to the review, (b) the providing to that faculty member a copy of the chairperson's tentative recommendation(s), and (c) reasonable opportunity for the faculty member to submit a written response to be forwarded to each subsequent level of review;
7. As long as a faculty member is employed by the University and for at least three years thereafter: maintenance of annual review forms, summaries of annual discussions between the chairperson and faculty member, recommendations, and all other writings used in or resulting from the annual reviews of that faculty member;

8. Availability to each faculty member of all writings used in or resulting from the annual reviews of that faculty member.

Each year the chief academic officer of each campus shall (a) require of each chairperson an assessment of the performance of all faculty members in the academic unit, including an identification of all faculty development needs and of all problems in performance of faculty, (b) take steps designed to insure compliance on that campus with all criteria and procedures for annual reviews, and (c) provide the Chancellor with a written report indicating the extent of compliance during the past year, as well as any needs and problems identified and solutions planned.

NOTE: A University-wide committee has been established for the purpose of recommending criteria and procedures for an annual review of all administrative officers of the University. A report from this committee will be presented to the Board of Trustees at a fall 1989 meeting for appropriate action of the Board.

The annual review of each administrative officer shall serve as the basis for decisions relating to salary and continuation as an administrator. Furthermore, this review is to provide guidance and assistance to all administrative officers in their professional development.

October 2, 2001 (Revised)
September 18, 1998 (Revised)
August 11, 1998 (Corrected)
June 6, 1997 (Revised)
April 25, 1997 (Revised)
September 16, 1994 (Revised)
June 16, 1989 (Revised)
January 23, 1987 (Revised)
September 17, 1982 (Revised)
June 18, 1982 (Revised)
February 8, 1980 (Revised)
April 20, 1962, and Revisions
AUTHORIZATION TO OFFSET AMOUNTS DUE UNIVERSITY BY AN EMPLOYEE AGAINST AMOUNTS OWED BY UNIVERSITY TO THAT EMPLOYEE

The University shall have the right to set off against amounts due and payable to an employee, including a student-employee, by the University those liquidated amounts due and payable by the employee to the University for any reason, with the University then paying the net amount remaining to the employee in full satisfaction of his or her wages or other amount due, as follows:

1. If the amounts owed by the employee to the University were the result of moneys advanced to the employee or misappropriation by the employee of moneys or personal property belonging to the University, the University may set off amounts owed to the University against all wages or other moneys owed to the employee.

2. In all other cases of setoffs against an employee's wages, the University may only set off amounts owed the University against those wages which are above the statutory minimum hourly wage.

3. If the amounts owed to student-employees constitute payments for work-study or are student loans under a program guaranteed or established by the U.S. Government, any set off shall be subject to laws and regulations governing those programs.

4. The University may set off amounts owed to the University against all sums owed to an employee other than wages, or student work-study or loan payments.

Subject to the above limitations, each Chancellor, through the business officers of that campus, may develop with an affected employee a repayment plan for successive offsets so that the entire amount owed to the University is not offset on a single occasion; provided, however, that no such plan shall be developed in the instance of any final settlement of accounts, such as where a final check for wages for a terminating employee may be involved.

This Board Policy shall be reflected in faculty, staff and student handbooks.

January 20, 1995 (Revised)
June 18, 1982
BOARD POLICY

CONTRACTING AUTHORITY

I. General Authority

The President and the Chief Fiscal Officer are authorized and directed to serve as the contracting officers, fully authorized to execute contracts on behalf of the Board of Trustees, in its name, or on behalf of the University of Arkansas in that name.

Any contract shall indicate the particular campus of the University of Arkansas for which the contract is applicable. Contracts are not to be made in the name of a campus as a contracting party since there is only one legal entity capable of contracting for the one institution ("University of Arkansas"), either in that institutional name or in that of its governing board ("Board of Trustees of the University of Arkansas"). Contracts made in the name of a campus, school or college, academic department, etc., are unenforceable.

The President is authorized to delegate, or withdraw such delegation, to the Chancellors, Vice President for Agriculture, or other appropriate individuals, the authority to contract in the name of the University of Arkansas for business activities in the normal course of operations when it is deemed that the efficiency, effectiveness, and best interests of the University will be well served by such delegation, and provided that such agreements must receive appropriate legal review or be entered into upon standard contract forms developed, or approved for such purposes, by the General Counsel of the University. Further, the President shall not delegate authority for contracts which include (a) a commitment to build or renovate a facility, (b) a commitment to initiate or expand an academic program, (c) a commitment to continued expenditures of University funds beyond the term of the contract, and (d) a contract amount which exceeds $250,000 individually or $250,000 in the aggregate when involving connected transactions. The President shall establish procedures for the review of contracts for professional and consultant services prior to their execution pursuant to the authority delegated by the President under this policy.

II. Personnel Actions

With reference to contract decisions regarding employment with the University of Arkansas, all personnel actions of campus personnel originate on the separate campuses, but are not official until signed by the President or his/her designee, if the President has delegated authority as provided herein. Salaries of appointed personnel cannot be paid until the personnel action forms have been completed.

The President shall be responsible for carrying out the appointment process for Chancellors, Vice President for Agriculture, Director of the Arkansas Archeological Survey, Director of the Criminal Justice Institute, and staff members of the System Administration. Personnel actions involving the appointment of Vice Chancellors, Deans, Distinguished Professors, Associate Vice President for the Cooperative Extension Service, and Associate Vice President for the Agricultural Experiment Station will be the responsibility of the Chancellors or the Vice President for Agriculture, provided that the Chancellors and the Vice President for Agriculture
must consult with the President on appointments to such positions prior to the time that any action has been taken and shall remain in regular consultation throughout the process, including interviews of finalists by the President at his/her discretion. No person shall be appointed to such a position without the prior approval of the President.

The President is authorized to delegate, or withdraw such delegation, to the Chancellors, Vice President for Agriculture, or other appropriate individuals, any other personnel actions for non-classified or classified personnel. When authority on personnel actions has been delegated, the designee shall provide for the maintenance of complete files on all personnel actions delegated and such files shall at all times be immediately and completely open to the President, Chief Fiscal Officer, or other University official(s) designated by the President. Individuals delegated authority by the President shall be held responsible for ensuring compliance with all personnel policies and procedures of the University and the State of Arkansas.

III. Contracts for Research and Sponsored Programs

The President is authorized to delegate to the Chancellors, to the Vice President for Agriculture, and to other appropriate officials, the authority to review, approve, and sign all applications or proposals for research and sponsored programs. The President may, in his discretion, establish a procedure for reports to be submitted to the Vice President for Finance and Administration those applications or proposals which involve a capital outlay by the University, a commitment for a new academic program, or a continuing commitment obligating the University beyond the period of the contract or grant or to report other matters in connection with research and sponsored programs.

All contracts or grants resulting from applications or proposals for research and sponsored programs shall be executed by the President or Vice President for Finance and Administration unless the President has delegated authority as provided in Section I of this policy.

IV. Lease or Rental Agreements

The President and the Vice President for Finance and Administration are authorized to execute lease, license, facility use or rental agreements on behalf of the Board of Trustees, in its name, or on behalf of the University of Arkansas in that name.

The President is authorized to delegate, or withdraw such delegation, to the Chancellors, Vice President for Agriculture, or other appropriate individuals the authority to lease, rent or license property owned by the University for residential purposes, for University-related programs or activities and for other purposes approved by the President. Any such lease, license, facility use or rental agreement shall be on a standard form reviewed and approved by the General Counsel and shall not exceed a term of two years.
The President is authorized to delegate, or withdraw such delegation, to the Chancellors, the Vice President for Agriculture, or other appropriate officials, the authority to lease property in the name of the University of Arkansas for use by a campus, division or unit of the University for activities in the normal course of operations when it is deemed that the efficiency, effectiveness and best interests of the University will be well served by such delegation. Such agreements must receive appropriate legal review or be entered into upon standard contract forms developed, or approved for such purposes, by the General Counsel of the University. The President shall not delegate authority to lease property for use by the University for a term in excess of two years or for payments over the term of the lease in excess of $250,000.
EMERITUS STATUS

I. Eligibility for Emeritus Status

In recognition of distinguished service to the University of Arkansas, retiring employees may be awarded emeritus status at the rank or title held at the time of retirement.

In order to be considered for emeritus status, an individual must be appropriately recommended and meet at least one of the following conditions:

1. The retiring individual is age 65 or older and has at least five years of continuous service with the University.
2. The retiring individual is age 62 or older and has at least 10 years of continuous service with the University.
3. The retiring individual has at least 20 years of continuous service with the University.
4. The retiring individual has elected to retire early under the early retirement provisions of Administrative Memorandum 430.2.

II. Procedures for Awarding Emeritus Status

In order for emeritus status to be conferred by the Board of Trustees, the individual must be recommended by the chief executive officer of the campus or unit. The President will recommend the final list of individuals to receive emeritus status.

Emeritus status will normally be conferred once each year by the Board of Trustees effective on July 1 for those individuals who have retired prior to that date. The President will receive recommendations no later than February 15, or such other date as may be specified, from the chief executive officer of the campus or unit.

III. Privileges of Emeritus Status

Emeritus status entitles the recipient to the following privileges:

1. Presentation of a certificate or resolution appropriate for framing;
2. Use of the title;
3. Continued campus faculty membership status for those with faculty rank, but without vote in the campus faculty governance body;
4. Inclusion in the campus directory, catalog, and other listings of campus faculty/staff;
EMPLOYMENT PERIODS

The following employment periods are established to govern employment with the University of Arkansas on all of its campuses and in all of its programs and activities, effective for, and hereby incorporated as a part of, all personnel actions for employment to perform personal services during the period beginning July 1, 1983, and/or thereafter:

1. Administrative Employees

The President of the University shall serve at the pleasure of the Board of Trustees, unless otherwise provided by contract. The vice presidents, members of the System staff, and the Chancellors shall serve at the pleasure of the President, unless otherwise provided by contract. Vice chancellors, associate vice chancellors, and assistant vice chancellors shall serve at the pleasure of their appropriate Chancellors, unless otherwise provided by contract. Termination of employment in such positions shall be effected by a notice, in writing, thirty days in advance thereof.

2. Faculty Employees

(A) Faculty members who have been awarded tenure, heretofore or hereafter, have a right to continuous employment except for dismissal for cause (according to the procedures in Section IV., C. of Board Policy No. 405.1) or for termination in the event of demonstrably bona fide financial exigency, reduction or elimination of programs, retirement, or resignation.

(B) Faculty members in tenure-track positions (assistant professor, associate professor, professor, distinguished professor, and University professor) who have not yet been awarded tenure, heretofore or hereafter, may be terminated effective at the end of a year by a written notice, given in advance, according to the following schedule of time: (a) in the first year of his/her employment, not less than 90 days before the employment ceases; (b) in the second year of his/her employment, not less than 180 days before the employment ceases; and (c) not later than twelve months before the expiration of the employment after the employment has continued for two or more consecutive years. "Year" will be either fiscal year (July 1 through June 30 next) or academic year (fall and spring semester of the same fiscal year). For purposes of (c) above, the employment for the last year shall be for an academic or fiscal year according to the employment period previously served by the individual.

These termination notice periods are those specified under IV.B., "Non-Reappointment," in Board Policy No. 405.1. In addition to termination as outlined here, these employees may be dismissed for cause, or terminated in the event of demonstrably bona fide financial exigency, reduction or elimination of programs, retirement, or resignation, pursuant to Board Policy No. 405.1.
5. Use of the library;

6. Eligibility to purchase a faculty/staff parking decal;

7. Faculty/staff admission to campus activities and events;

8. Waiver of fees for enrollment in University courses on a space available basis.

IV. Responsibility of Recipients of Emeritus Status

Emeritus employees are expected to assist and support the University in their areas of competence, particularly in an advisory capacity, when requested to do so.

June 16, 1989 (Revised)
February 8, 1980 (Revised)
March 19, 1940
(C) Faculty members and other academic employees in positions for which tenure may not be awarded (part-time faculty in the ranks of assistant professor, associate professor, professor, distinguished professor, and University professor; clinical, research, adjunct, or visiting faculty; research associates or research assistants; graduate associates, graduate assistants, instructors, assistant instructors, master lecturers and lecturers; and faculty in clinical attending positions at the University of Arkansas for Medical Sciences notwithstanding that such faculty may be designated as assistant professor, associate professor or professor) may be terminated at any time, or dismissed for cause under the procedures of Board Policy No. 405.1. Termination is effected through the giving of a notice, in writing, of that action at least sixty days in advance of the date the employment is to cease.

3. **Staff Employees**

All staff employees of the University, whether full-time, part-time, extra help, or otherwise, may be terminated at any time or be dismissed for cause under University procedures. Termination is effected through the giving of a notice, in writing, of that action at least thirty days in advance of the date the employment is to cease.

4. **Students and Hourly Employees**

Students and hourly employees are hired to work at the pleasure of the University and, therefore, may be terminated at any time without notice.

5. **Procedure**

The President shall approve procedures to be followed at each campus, division or unit of the University for the utilization and processing of personnel action forms for each employee or for such other system or method of electronic or data entry record keeping or automated information system for employees. The procedures shall be designed to indicate for each employee the employee's title, salary amount and the fact of current employment with the University subject to this Board Policy on Employment Periods. The procedures shall also provide a means for communicating this information to employees.

It is the sense of the Board of Trustees that the establishment, in one Board Policy and procedure, of the periods of employment for all University employees will serve to clarify rights and obligations of such employees, reduce administrative time, effort, and expense in processing unnecessary personnel action forms which are duplicative in nature, make employment periods more flexible so that the expense of personal services may be more responsive to financial resources available to the University at any one time, and will assist in the proper management of the University.

September 18, 1998 (Revised)
April 18, 1998 (Revised)
September 16, 1994 (Revised)
March 27, 1989 (Corrected)
January 23, 1987 (Revised)
July 19, 1983 (Corrected)
April 15, 1983 (Revised)
January 7, 1983
NEPOTISM

The University recognizes that potential conflicts of interest may exist when members of the same immediate family are employed by the University, particularly in the same department, unit or division. To avoid conflicts of interest which may result from such employment, immediate family members should not participate in decisions to hire, retain, promote or determine the salary of the other. It is the responsibility of the President, each Chancellor, the Vice President for Agriculture, the Director of the Criminal Justice Institute, and the Director of the Arkansas Archeological Survey to assure that one immediate family member shall not have direction or supervision of the other and shall not participate in decisions to hire, retain, promote or determine the salary of the other. Exceptions to this policy may be made in writing with justification by the President, each Chancellor, the Vice President for Agriculture, the Director of the Criminal Justice Institute or the Director of the Arkansas Archeological Survey. Exceptions involving immediate family members of a Chancellor, the Vice President for Agriculture, the Director of the Criminal Justice Institute or the Director of the Arkansas Archeological Survey shall be made by the President. For purposes of this policy, “immediate family member” shall mean an employee’s spouse, children of the employee or his or her spouse, and brothers, sisters, uncles, aunts, nieces, nephews, or parents, whether by blood or marriage, of the employee or his or her spouse.

This policy is supplementary to any provisions of applicable law.

June 9, 2000 (Revised)
November 20, 1971
OUTSIDE EMPLOYMENT OF FACULTY AND ADMINISTRATIVE STAFF MEMBERS
FOR COMPENSATION

While emphasizing the fact that full-time faculty and non-classified administrative staff members of the University are obligated to devote their working time and efforts primarily to University activities, the University recognizes that a limited amount of outside work for private compensation may be advantageous to all concerned. Deans, department heads, directors, vice chancellors, chancellors, vice presidents, and the president are included as administrative staff. Such persons are therefore encouraged to engage in outside employment which will affirmatively contribute to their professional advancement or correlate usefully with their University work. This employment shall not interfere in any substantial way with the employee's University duties nor conflict with his/her University assignments. Written approval from department head and/or dean shall be obtained in advance of such outside employment. Each dean or similar officer shall keep records on outside employment by personnel in his/her college or administrative unit. The report should include actual time spent during the reporting period. Such records shall be reviewed by the appropriate administrator and submitted to the Chancellor or Vice President for Agriculture by September 30 of each year and such records shall be reviewed periodically by the appropriate administrator. The employee shall always make it clear the outside employment is his/her own responsibility and that in it he/she does not act as an agent or representative of the University. University facilities or property shall not be used except with permission of the department head or dean, and the payment of appropriate fees may be required.

September 26, 1997 (Revised)
June 11, 1993 (Corrected)
April 30, 1993 (Revised)
June 15, 1990 (Revised)
January 15, 1988 (Revised)
June 19, 1958 (Revised)
June 5, 1916
PATENT AND COPYRIGHT POLICY

I. Patent and Copyright Policy

A. Preamble

As a state-supported institution of higher learning, the University of Arkansas has a responsibility for and an interest in the advancement of knowledge and creative work that will enhance its educational mission and promote the economic and social welfare of the public it serves, particularly the people of the State of Arkansas. This responsibility and interest are advanced by engaging in research, the results of which may, on occasion, have commercial applications which are patentable or copyrightable. While Inventions and copyrightable works are not the primary objectives of University Research, when they occur the University has the responsibility of insuring that such Inventions and Works are used and controlled in a manner that benefits the public, the Inventor or Author and the University to the fullest extent possible.

To achieve this purpose, the University adopts this policy to meet the following objectives:

1. Assist the faculty, students, and staff in matters related to Inventions, patents, and copyrights and provide an environment that will encourage the disclosure and development of meaningful Inventions and Works;

2. Obtain the proper benefits for Inventors and Authors and for the University from commercial applications of University Research and apply funds accruing to the University from these applications to the support of research and other scholarly activities at the University;

3. Encourage and facilitate collaborations with sponsors of University Research by appropriately allocating the rights to Inventions and Works which result from Sponsored Research consistent with federal laws; and

4. Determine the rights and interests of all parties in University Research and Sponsored Research according to established, uniform procedures.

For purposes of this policy and of Board Policy 210.2, Copyright and Distance Learning, the University of Arkansas shall mean and refer to the following principal campus units, divisions and administrative units: The University of Arkansas, Fayetteville; The University of Arkansas for Medical Sciences (including the Area Health Education Centers); The University of Arkansas at Little Rock; The University of Arkansas at Monticello; The University of Arkansas at Pine Bluff; the University of Arkansas Community College at Batesville; Cossatot Community College of the University of Arkansas; the University of Arkansas Community College at Hope; the University of Arkansas Community College at Morrilton; Phillips Community College of the University of Arkansas; Division of Agriculture; Arkansas Archeological Survey; the Criminal Justice Institute; the Cammack Campus; and the System Administration. These educational and administrative units, together with certain authorized adjuncts to each and those campuses or units later added by merger.
or otherwise, constitute the University of Arkansas for which the Board of Trustees is the governing Board of control and are also referred to collectively as the University of Arkansas System

B. Definitions

The following definitions are employed in interpreting and implementing this policy:

1. "University" means the University of Arkansas and any entity or activity under the authority of the Board of Trustees of the University of Arkansas.

2. "University Research" means any research or development activity which is directly related to the duties and responsibilities for which a person has been compensated by or through the University or for which facilities owned, operated, or controlled by the University are used.

3. "Sponsored Research" means University Research for which the University has received external support. (For purposes of this policy, external support includes funds received by the University as part of a lease agreement.)

4. "Invention" refers to any material capable of legal protection arising out of University Research and includes any discovery, invention, process, know-how, design, model, computer software (if patentable), strain, variety, or culture of an organism, or portion, modification, translation, or extension of these items but excludes Works as defined hereinafter which are not patentable. It includes marks used in connection with these. (The term "mark" refers to trademarks, service marks, collective marks, and certification marks.) It also includes tangible research property, i.e., tangible items produced in the course of research such as, but not limited to, e.g., biological materials, engineering drawings, integrated circuit chips, computer databases, prototype devices, circuit diagrams, and equipment. (Items of tangible research property may be associated with one or more intangible properties such as patents, copyrights, and trademarks.)

5. "Inventor" means a person who creates, develops or discovers an Invention and includes the definition of "inventor" used in United States Patent Law.

6. "Work" means an original work of authorship arising out of University Research which is protectable by copyright. It includes books, journals, software, computer programs, musical works, dramatic works, videos, multimedia products, sound recordings, pictorial and graphical works and other similar works.

7. "Author" means a person who develops or creates a Work and includes the definition of "author" used in the United States Copyright Act. The University may also be an Author under certain circumstances such as when a Work constitutes a "University Work."
8. "University Work" means a Work created specifically for institutional purposes in the course of a person's employment with the University.

C. **Statement of Policy**

1. It shall be the policy of the University to acquire and retain legal title to all Inventions created by any person or persons to whom this policy is applicable. This policy is established in furtherance of the commitment of the University to the widest possible distribution of the benefits of University Research, the protection of Inventions resulting from such research, and the development of Inventions for the public good.

2. Inventors shall retain rights in Inventions which the University has chosen not to claim under this policy or pledged to a third party as a result of a grant, contract, cooperative agreement, or other Sponsored Research agreement.

3. Rights to Works shall be determined according to the provisions of this policy which apply to copyrights.

D. **Applicability of Policy**

1. This policy shall apply to all persons employed, compensated or appointed by the University and to anyone using facilities owned, operated, or controlled by the University. It shall also apply to all Inventions and Works financed, in whole or in part, from funds under the control of the University.

2. Employees engaged in external consulting work or business are responsible for ensuring that agreements emanating from such work are not in conflict with this policy or with contractual commitments of the University. Such employees should provide affirmative notice to the other parties to such agreements, informing them of the obligations of the employees to the University and the possible applicability of this policy to such agreements.

E. **Obligations of Inventors and Waiver and Notice Rights**

1. **Disclosure.** All persons to whom this policy is applicable shall furnish to the University a full and complete disclosure of any Invention promptly after it is created or conceived or first reduced to practice. Such persons shall cooperate in a timely and professional manner with the University or with patent or other counsel in protecting Inventions and perform all acts necessary for the University to fulfill its obligations under University Research, including the execution of assignments. The University may require technical advice and assistance from Inventors in the development and licensing of their Inventions.

2. **Assignment.** All persons to whom this policy is applicable shall, upon request, assign all Inventions and patents to the University, except those which might be owned by third parties.
pursuant to Sponsored Research agreements and those which might result from independent work or permissible consulting activities without use of facilities owned, operated, or controlled by the University.

3. **Waiver.** If the University chooses not to protect or commercialize an Invention, the University may, at its sole discretion, waive its rights to the Invention and assign ownership of the Invention to the Inventor as allowed by law, subject to the rights of third parties and to the reservation by the University of a license to practice the Invention for University purposes. The minimum terms of such license shall grant the University the right to use the Invention in its internally administered programs of teaching, research, and public service on a perpetual royalty-free basis. The University may retain more than the minimum license rights and the assignment or license may be subject to additional terms and conditions, such as revenue sharing with the University or reimbursements of the costs of statutory protection, when justified by the circumstances of development.

4. **Notice.** The University will inform Inventors in a timely manner of its substantive decisions regarding protection, commercialization and/or disposition of Inventions which are disclosed under this policy. The initial notice of such a decision to an Inventor should be given no later than six (6) months after disclosure of the Invention to the University.

5. **Independently-Owned Patents.** The University may accept assignment of patents or other intellectual property from parties to whom this policy does not apply provided that such action is determined to be consistent with the public interest and educational mission of the University. The patents or other intellectual property so accepted shall be administered in a manner consistent with the administration of Inventions under this policy.

F. **Distribution of Revenues**

1. In consideration of the disclosure and assignment of Inventions, the Inventor, or the Inventor's heirs, successors, or assigns shall receive fifty percent (50%) of the first two hundred thousand dollars ($200,000) of Net Revenues from the commercialization of an Invention. The remaining fifty percent (50%) shall be distributed to the University in the following manner: forty-five percent (45%) to the chief executive officer of the Inventor's campus or division for distribution within the campus or division for patent administration and research purposes; and five percent (5%) to a fund to be managed and distributed by the University of Arkansas for patent administration and research purposes. Any Net Revenues above $200,000 shall be distributed as follows: (a) thirty-five percent (35%) to the Inventor or the Inventor's heirs, successors, or assigns; (b) sixty percent (60%) to the chief executive officer of the Inventor's campus or division for distribution within the campus or division for patent administration and research purposes; and (c) five percent (5%) to a fund to be managed and distributed by the University for patent administration and research purposes. If there are joint Inventors, Net Revenues shall be distributed equally among them absent a mutual agreement to the contrary.
2. "Net Revenues" shall mean for this purpose all Revenues received by the University from the commercialization of Inventions and Works minus the costs incurred by the University for patenting, licensing, and the protection and maintenance of patent and copyright rights and other documented costs incurred by the University directly related to commercialization.

3. "Revenues" shall mean cash from payments including, but not limited to, royalties, option fees, license fees or from the sale of Equity but shall not include research support received by the University as part of the consideration for licensing an Invention or Work in lieu of an option free, license fee or royalty. Inventors shall have no entitlement to a share of such research support as personal income.

4. Net Revenues will be distributed normally on an annual basis, with payments being made within sixty (60) days after the end of a calendar year in which Net Revenues from the Invention or work have accrued.

G. Equity

1. In agreements with business entities relating to rights in Inventions and Works, the University may receive Equity as partial or total compensation for the rights conveyed. In any such instance, the University shall share any such Equity with the Inventor or Author in the same manner as Net Revenue is shared pursuant to Section I.F above. Consistent with Arkansas Code § 19-11-717 and campus or unit conflict of interest policies, and subject to review and approval by the Chancellor or other chief executive officer of the unit of the University, the President and the Board of Trustees, Inventors or Authors may hold direct, individual Equity in a business entity that has an agreement with the University relating to the commercialization of Inventions or Works. The University, in its sole discretion, may require an Inventor or Author who holds direct, individual Equity in such a business entity to waive any right which the Inventor or Author may have to share in Equity and/or Net Revenues through the University under Section I.F above.

2. Dividend income and income from the sale or disposition of Equity held by the University pursuant to agreements relating to the commercialization of Inventions or Works shall belong to the University and be distributed in accordance with the provisions of Section I.F unless an Inventor or Author has been required to waive such rights under Section I.G.1 above. Such Equity shall be sold or disposed of at a time and in a manner selected solely at the discretion of the University, subject to restrictions imposed by law, the underwriters of the stock issuance or the business entity. Dividend income and income from the sale or disposition of Equity held directly by an individual Inventor or Author shall belong to the Inventor or Author and may be sold or disposed of at a time and in a manner selected solely at the discretion of the Inventor or Author, subject to restrictions imposed by law, the underwriters of the stock issuance or the business entity.
3. An Inventor or Author shall not serve as a member of the board of directors or other governing board or as an officer or an employee (other than as a consultant) of a business entity that has an agreement with the University relating to the commercialization of Inventions or Works and in which the University has Equity without prior review and approval by the Chancellor or the chief executive officer of the unit of the University. When requested and authorized by the University, an employee may serve on behalf of the University as a member of the board of directors or other governing board of a business entity that has an agreement with the University relating to the commercialization of Inventions or Works and in which the University has Equity.

4. "Equity" shall include, but not be limited to, stock, securities, stock options, warrants, buildings, real or personal property, or other non-cash consideration. Inventors shall not be entitled to receive a share of the subset of University-owned Equity which consists of buildings, real or personal property, or other non-cash consideration.

H. Sponsored Research

Rights to Inventions and Works made under Sponsored Research are determined by the contractual or grant agreements between the University and the sponsor. Except in limited circumstances where the University determines that the waiver of such rights is appropriate in fulfilling its educational mission, allocation of rights to Inventions and Works made under Sponsored Research shall be consistent with this policy.

I. Publication Rights

In all Sponsored Research, the right shall be reserved for Inventors, Authors and the University to publish and disseminate the knowledge gained and the results obtained. The University may grant a sponsor a limited review period (normally thirty (30) days) prior to submission for publication in order to protect proprietary information and any technology which may be the subject of a patent application.

J. Copyrights and Computer Software

1. Copyrights to, and royalties from, textbooks, reference works, submissions to scientific journals, and other Works (excluding computer software and Technology Enhanced Course Materials) produced by persons to whom this policy is applicable as a part of their normal teaching, scholarly and aesthetic activities at the University or on approved off-campus duty assignments, and which do not result from projects specifically funded in whole or in part by the University or by a sponsor of the University, shall belong to the Author or Authors and may be retained or assigned by them. If, on the other hand, the University provides its own funds, or a sponsor's funds, to finance (in whole or in part) a specific research or educational project (herein "commissioned Works") and such Works are produced by persons to whom this policy is applicable as a result of the project or the Works constitute University Works, ownership of
copyrights and Revenue rights therein shall reside in the University. Revenues generated by the commercialization of such Works may be shared with the Authors or creators according to Section 1.F of this policy or on other terms as set by the University in its sole discretion.

2. All rights to computer software, including computer programs, computer data bases, and associated documentation (herein "computer software"), whether copyrightable or patentable, produced by any person to whom this policy is applicable shall belong to the University, with the exception of software which constitutes Technology Enhanced Course Materials governed by Board Policy 210.2. Revenues generated by the commercialization of computer software shall be shared with the Authors/Inventors according to Section 1.F of this policy. Computer software produced on an Author's own time or through permissible consulting activities and without the use of facilities owned, operated, or controlled by the University shall belong to the Author and all rights thereto may be retained or assigned by the Author.

3. It shall be the responsibility of the Author or creator to notify the University of the development of all commissioned Works, University Works and computer software.

II. Patent and Copyright Policy Administration

A. University Patent and Copyright Committee

The President shall appoint a University Patent and Copyright Committee of nine (9) members with one (1) representative from each of the four (4) four-year campuses, the Medical Sciences campus and the Division of Agriculture and a single representative agreed upon by a consensus of the two-year campuses and other units of the University. The specific representative of the two-year campuses and other units of the University may be selected on a rotating basis with a limit on the number of consecutive annual terms that a person from any one of such entities may serve. The Vice President for Finance and Administration and the Associate Vice President for Legal Affairs shall be ex officio members of the Committee. The General Counsel shall serve as legal advisor to the Committee. A chairman shall be elected from among the membership of the Committee. The Committee shall meet at least annually and at other times upon the request of the chairman or the President. The Committee shall be responsible for:

1. Reviewing the operation of the University Patent and Copyright Policy and proposing policy changes if needed;

2. Reviewing proposed exceptions to the established policy;

3. Resolving issues referred by campus patent and copyright committees;

4. Advising the President on patent and copyright policy matters as requested.
B. Campus Patent and Copyright Committees

1. Each campus of the University shall establish a committee composed of faculty and staff which shall be responsible for implementing the University Patent and Copyright Policy on the particular campus. Any campus which has received less than five (5) Invention disclosures during a fiscal year shall not be required to establish or maintain a committee and may request assistance from such committee of any other campus in implementing this policy. The committees shall consist of no less than five (5) members, appointed by the Chancellor or chief executive officer, and shall meet no less than on a quarterly basis. A chairman shall be elected from among the membership of the committees.

2. For the Fayetteville campus only, the committee shall be composed of no less than eight (8) members; three (3) of which shall be appointed from the Division of Agriculture by the Vice President for Agriculture. Disclosures for patentable or copyrightable material emanating from the Fayetteville campus and the Division of Agriculture shall be administratively controlled by the Fayetteville campus committee.

3. In matters of a substantive legal nature, the committees shall seek the advice and assistance of the General Counsel and/or the Associate Vice President for Legal Affairs.

C. General Responsibilities

The committee shall have the general responsibility of:

1. Reviewing Invention disclosures submitted to the University for patenting consideration;

2. Evaluating Inventions for patentability, as well as scientific merit and practical application;

3. Appointing ad hoc technical subcommittees to assist the committee in evaluating Inventions;

4. Seeking University approval of outside technical assistance in evaluating Inventions;

5. Determining patent or related property rights or equities held by the University in an Invention or Work;

6. Providing scientific and technical assistance to approved patent management organizations to achieve the realization of full benefits of University Inventions that have commercial potential;

7. Seeking initial resolution of campus disputes relating to rights in Inventions and Works; and

8. Reviewing Works (including computer software) submitted for copyright consideration.
D. Committee Procedure

Normally within thirty (30) days of the receipt of an Invention disclosure, the committee will submit to the Chancellor or other chief executive officer or the Vice President for Agriculture its recommendation regarding the disposition of an Invention. Such recommendation shall be forwarded within ten (10) days of receipt to the President. In most instances, the recommendation will consist of one of the following:

1. University should proceed to secure a patent or register a copyright or a trademark;

2. The matter should be submitted to a patent management organization with which the University has a contract for review, report, and possible management by the patent management organization;

3. Negotiations should be entered into with industry whereby continued research and development within the University will be funded pursuant to contract with a corporation or firm which would receive certain rights regarding the Invention in return for Revenue or, under limited circumstances, an assignment in return for payment of additional sums;

4. Commercial or education values involved are so slight and/or incompatible with the interests of the University as to indicate that the University should relinquish any property interest to the Inventor or Author or his/her assigns.

October 2, 2001 (Revised)
June 13, 1986 (Revised)
June 18, 1982 (Revised)
November 18, 1977 (Revised)
May 18, 1973 (Revised)
September 29, 1967 (Revised)
October 7, 1966 (Revised)
May 17, 1945
POLITICAL ACTIVITY

University employees, as citizens, have the right to engage in political activity. However, no employee may involve the institution's name, symbols, property, or supplies in political activities.

Any employee who intends to seek public office or to assume a major role in a political campaign is obligated to discuss his/her plans with his/her supervisor. If the supervisor determines that the activity will impinge to any extent upon the full discharge of the employee's responsibilities to the University, the plans must be reviewed through regular administrative channels to the President's office for a determination of work-load and salary adjustment.

Involvements which require part- or full-time services, and for which more than token compensation is received, will require a reduction of work-load and pay, leave-of-absence, or resignation, depending upon the extent of the activity.

March 7, 1975
Faculty Affairs - Promotion and Tenure

The Faculty Development Office sends a newcomer packet with information about Little Rock, UAMS and the promotion and tenure process to all new faculty who are also invited to make an appointment with Lee Lee Doyle, PhD, Assistant Dean for Faculty Development to discuss career planning at UAMS. We are located in 4D40 (University Hospital). The promotion and tenure document, cover page, the teaching portfolio, the academic diary, and valuable tips for packet assembly are available at the bottom of this page.

2005 Guidelines for Promotion and Tenure Packets

Due Date: October 3, 2005 by 4 PM

Number due: 18 packets - four with publications (1 each for primary & secondary investigator and one for the Chair of the Promotion and Tenure Committee, Lee Lee Doyle, Ph.D.)

Where due: Connie Albert in the Office of Faculty Affairs (4D40 - University Hospital)

Our summer promotion and tenure workshops are 1 hour informal career planning sessions offered by members of the Promotion and Tenure Committee and are open to all faculty and administrative personnel involved in the promotion and tenure process in a support capacity.

Connie S. Albert (csalbert@uams.edu) is the contact for new faculty appointments, promotion and tenure and faculty database issues. Contact her by email or phone (501.526.4684)

Tenured and Non-Tenured Faculty Tracks

UAMS College of Medicine Principles for Adjunct Faculty Appointments

Frequently Asked Questions

AAMC Recommendations for Preparing a Curriculum Vitae

Educator's Portfolio

Educator's Portfolio Template

Criteria and General Guidelines for Faculty Appointments Promotion and Tenure

Promotion and Tenure Cover Page

Valuable Tips for Preparing the Packet

Preparing the Packet slide show

Academic Diary - One solution to tracking academic activities

University of Arkansas for Medical Sciences
4301 W. Markham St., Little Rock, AR 72205

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Faculty Tracks

According to the role they play in the College of Medicine, faculty members are appointed to either one of two non-tenure tracks or one of the three tenure tracks:

Non-Tenured Pathway

**Clinician Attending** faculty are appointed on an annual basis and are not eligible for tenure. The emphasis is on patient care; research and teaching are not of primary importance.

**Research Scientists** are appointed on an annual basis and not eligible for tenure. The emphasis is on collaborative research.

Tenured Pathway:

**The Clinician Educator** focuses on excellence in teaching and scholarship. The expectations for teaching and clinical care will be related to time allotted for each activity. Clinical Educators are expected to demonstrate scholarly achievement in education as well as in clinical activities.

**The Clinician Scientist** focuses on research and patient care primarily. In addition to demonstrating clinical excellence, the clinical scientist must obtain support for research.

**Basic Scientists** focus on teaching and research. Basic scientist faculty are expected to demonstrate the ability to win competitive grants to support independent research.

The track is chosen by the Departmental Chairman and must be approved by the Dean. Faculty recruited at the rank of Associate Professor or above must be approved by the Promotion and Tenure Committee. It is important for new faculty members to meet with his/her Departmental Chair and/or Division Director to discuss what is expected of them and how time will be divided among research, teaching, and service.

Each faculty member should be familiar with the Criteria and General Guidelines for Faculty Appointments Promotion and Tenure especially those sections relating to his/her track and rank. **It is the responsibility of each faculty member to maintain a personal file that documents scholarly achievements in the areas important to the track.** An Educator’s Portfolio is available at this site as is an informal diary which can be used to record academic achievements. These files not only assist faculty in monitoring his/her own progress but will be used to prepare Promotion and Tenure applications as well. Promotion and/or Tenure should be regarded as rewarding the outcome of an ongoing, dynamic process of individual achievement in scholarly and academic areas which has been well documented. Promotion and Tenure workshops which assist faculty in understanding how to prepare an application are presented annually by the Office of Faculty Affairs. New faculty and faculty who are preparing to submit packets for Promotion and/or Tenure are urged to attend.

The Promotion and Tenure Committee considers the achievements of the individual in light of his/her own specific track, recognizing that faculty members will have different responsibilities. While quantity is considered, quality is of utmost importance. Faculty can’t simply document activity in an area, but must provide evidence documenting scholarly achievement in that area.
UAMS College of Medicine
Principles for Adjunct Faculty Appointments

Definition: Adjunct Faculty members are individuals who volunteer time and expertise to the College of Medicine. These individuals may have academic appointments in other UAMS Colleges or may practice their professions in the larger community outside UAMS.

Service to the College of Medicine:

1. All adjunct faculty members will be expected to make a substantial contribution to the College of Medicine through a variety of avenues, devoting a minimum of 20 hours of service annually. The hours may be spent teaching, attending, participating in research or other activities approved by the Department Chair and Dean.
2. Adjunct faculty members may serve on committees, but may not serve as chair.
3. Adjunct faculty members may participate in faculty meetings, but may not vote.

Adjunct Faculty Appointments, Renewal, and Termination:

1. Initial adjunct faculty appointments will be made by the Department Chair with the approval of the Dean or his/her designee.
2. Appointments will be to either the Adjunct Basic Scientist Pathway or the Adjunct Clinical Pathway.
3. Appointments at the level of Associate Professor or Professor must be approved by the Promotion and Tenure Committee.
4. Adjunct faculty may be promoted in accordance with the guidelines governing Adjunct Faculty in the Criteria and General Guidelines for Faculty Appointments, Promotion and Tenure (see COM Faculty Affairs website: www.uams.edu/facultyaffairs)
5. An initial adjunct faculty appointment will be for a period of one year. Thereafter, review of each adjunct appointment will occur every three years.
6. Review of each adjunct faculty member's service to the College of Medicine will be conducted by each Department Chair or his/her designee. It is recommended that each adjunct faculty member submit to his/her chair a report of activities performed in service to the College on an annual basis. These reports, in addition to input from COM Faculty members with whom adjunct faculty members have worked, will serve as the basis for review of adjunct appointments. An adjunct faculty appointment will be renewed by a Department Chair if that adjunct faculty member's service has fulfilled these principles and there is need for continued adjunct faculty service within the Department.
7. Renewal of appointments must be approved by the Department Chair and reviewed by the Associate Dean for Faculty Affairs. The Office of Faculty Affairs will facilitate reviews by delivering to each chair, annually, a roster that includes the names of his/her department's adjunct faculty members, their appointment "start dates," and an indication of which adjunct faculty members are due for review in that year.
8. Appointments may be terminated at any time by either the adjunct faculty member or the Department chair. Reappointments of self-terminated adjunct faculty members may be made in the future, should their interest and availability warrant such action.
9. Adjunct faculty will have no right of grievance of termination.

Benefits offered to Adjunct Faculty Members of the UAMS College of Medicine:

1. E-mail accounts – available once the adjunct faculty member is registered in SAP and FacFacts
2. Faculty I. D. badge
3. A certificate of appointment
4. Library privileges when on site at UAMS and AHECs
5. Courtesy parking on site at UAMS, via departmental mechanisms
6. Inclusion on all faculty rosters and lists as Adjunct Faculty
7. All UAMS publications sent to UAMS faculty members
8. Right to use adjunct title on professional stationery and cards
9. Faculty discounts at local merchants (listing available on UAMS HR website: http://www.uams.edu/ohr/benefits.asp)
10. Eligible for membership in UAMS Credit Union
11. Eligible to purchase computers/peripherals on UAMS contract via Intranet
12. Eligible for membership in UAMS Athletic Club/Wellness Center

College of Medicine, Council of Department Chairs, September 6, 2005 (www.uams.edu/facultyaffairs)
Faculty Affairs - FAQ

This new feature is added to help faculty members through the Promotion and Tenure process. If you don't find the question you want answered on this list, please E-mail your question to Doylelee@uams.edu and help us make this list more useful to all faculty members.

FAQ’s about Promotion and Tenure

Items in quotations are taken directly from the Promotion and Tenure Document

Q. When should I plan to go up for promotion?

- "It would be unusual for a person to be promoted to Associate Professor with less than 5 years experience ...."
- So plan to submit your packet in your 5th or 6th year.
- "Promotion to the rank of Professor is a high honor of the University and it is reserved for those members of the faculty who have demonstrated outstanding ability. It is not based on length of service alone. ... they should have considerable time and experience in rank..." so plan to submit your packet when you have evidence of a body of scholarly activity and national recognition that justifies this high honor.

Q. Can you explain the tenure clock?

- The tenure clock applies only to full time faculty in the Basic Scientist, Clinical Scientist or Clinical Educator track.

The tenure clock starts July 1 of the year you are appointed at the rank of Assistant Professor or above. If your date of initial appointment is between January 1 and June 30, this time does not count as a full year or any part of a year, but any appointment made before January 1 is counted as a full year.

A faculty member who has not achieved tenure by the end of his/her 6th year will receive a letter at the beginning of the 7th year informing him/her that this 7th year is a terminal year.

Tenure is rarely granted at initial appointment at any rank.

What sorts of letters of recommendation do I need and how do I get them?

- "Candidates considered for promotion to Associate Professor should have AT LEAST TWO letters of recommendation OBTAINED BY THE CHAIRMAN from recognized national authorities in a candidate's special field of interest NOT INVOLVED IN PRIOR TRAINING OR EMPLOYMENT. Other letters of recommendation are encouraged".

For Professor, "AT LEAST THREE letters of reference must be OBTAINED BY THE CHAIRMAN and submitted to the Dean of the College of Medicine prior to the decision to promote the faculty member to this senior rank. Letters for Basic and Clinical Scientists should come from outside the institution and from recognized authorities in the candidate’s special field of interest NOT INVOLVED IN PRIOR TRAINING OR EMPLOYMENT".
The usual method is that the faculty member provides his/her division or department head with a list of names of people who are considered experts in the candidate's areas of interest and expertise and who have attained the rank of Professor. These prospective references should not have been involved in previous training or employment of the candidate. The division or department head then usually sends a letter requesting an evaluation and recommendation for the candidate's application for promotion and/or tenure along with a copy of the P&T document from UAMS and the candidate's CV. The letters are then sent to the division or department head who makes sure they are put in the packet. **IT IS NOT APPROPRIATE FOR THE CANDIDATE TO SOLICIT HIS/HER OWN LETTERS OF RECOMMENDATION.**

**How do I document my scholarly achievements in education?**

- Clinical educators use this Teaching Portfolio and the Teaching Portfolio template. All clinical educators must use this form, and faculty members in other tracks are encouraged to use it as well.

  It is important for educators to include summaries of all available evaluations of their teaching rather than individual anecdotal ones. These summaries should be referenced to some sort of norm whenever possible.

**Q. Who decides when I should go up for promotion?**

- Your department chairman. In larger departments, your division chair may make the initial recommendation to your chairman.

**Q. Who appoints the P&T Committee?**

- The P&T Committee members must be Professors and the Dean of the College of Medicine chooses them.

**Q. Are promotion to Associate Professor and tenure always granted at the same time?**

- Generally this is the case; however, it is not always true. Occasionally, in unusual cases, they may be granted at different times. Also, if the initial appointment was made at the level of Professor, tenure is not automatically conferred but must be voted on at a later date by the committee.

**Q. Where can I get help getting ready for P&T?**

- The Office of Faculty Affairs puts on a series of P&T Workshops for faculty at specific levels in each Path. These workshops are listed on the Faculty Development Web page and on flyers posted around campus.

**Q. What happens if the Committee does not recommend promotion or tenure?**

- At the end of the P&T Committee meeting, if a faculty member's packet did not receive a favorable vote, the Chairman of the department is informed of this action, and he or she may choose to appeal this decision to the committee. If after these appeals are heard, the committee doesn't act favorably on the request, and the Dean concurs with the recommendation of the Committee, the faculty member may appeal the decision to the Dean.

  The P&T Committee only makes recommendations to the Dean who makes the final decision in the College of Medicine. The Dean's recommendations go to the Chancellor and from there to the President of the University of Arkansas.
Q. The Promotion and Tenure cover sheet asks for the percent of time a faculty member spends in Teaching, Research, and Service, and the Criteria and Guidelines give the mean and range appropriate for each track. How are these numbers used in the Promotion and Tenure process?

A. Each faculty member has an individual and unique role to play in the College of Medicine. While you are expected to be involved in teaching, research, and service, the amount of time you will spend in these activities varies depending upon your track. There are three tenure and two non-tenure tracks. The amount of activity in education, research, and clinical services determines the assignment to a given track and should fall within the ranges shown in the guidelines; however, even within a track, the amount of time you spent in these activities will vary depending upon the role(s) you have been assigned. Knowing what percent of time each faculty member is spending on these three activities allows the Promotion and Tenure committee to establish realistic expectations for scholarly activity from you in each of the areas of activity.

Q. Who should set these percentages?

A. The initial distribution of time should be established when you join the College of Medicine and should be the result of a discussion between you and the chair who is hiring you. The expected time distribution should be included in the Offer Letter you receive. Subsequently, time distribution should be reviewed yearly at the time of your annual review.

Q. What if the percents of time distribution don't actually reflect what I'm doing?

A. You should meet with your division or department head to discuss this concern. Often this may occur at the time of annual review, but it can be done at any time. After a discussion you may find that you need to change the time distribution to reflect your actual activities or you may need to change your activities, but the decision should be a mutual one between you and your division or department head. Occasionally, you may find that your duties have changed quite radically so that they are outside the guidelines for the track. In this case, if you are in your first three years as a faculty member, your chairman might need to meet with the Dean and discuss a change of track for you.

Q. What if my activities change from year to year?

A. You can indicate this by listing the activity percentages for each time period separately.

Q. If I can't find the answer to MY question here, what should I do?

- Send an E-mail with your question to Doyleleel@uams.edu and become part of our FAQ's.
Preparing Your Curriculum Vitae

Maintaining effective documentation of your academic history and achievements is critical to success in academic medicine. Consider the tips and tools on this site as you prepare your portfolio with an eye toward highlighting your unique qualifications. Use "Create My CV" to craft your CV, considering the "Tips and Strategies" to make the best impression; "Teaching Portfolio" explains what should be included in showcasing your teaching efforts. "Biographies" includes information about your biographical statement and links to the NIH Biosketch form and examples. It also addresses the "Executive Summary," a powerful tool to highlight your qualifications in ways that one’s CV often does not. For advice, review the questions and answers in "What if . . .?" or Send Us Your Question. For more information, consider the "Resources" we've identified.

Key points to keep in mind:

- Follow your institution’s guidelines for your internal CV, the CV you submit with promotion and tenure materials.
- Don’t wait to create your external CVs, biographical statements and executive summary.
- Create a teaching portfolio.
- Develop a system that works for you to facilitate updating your package.
- Update your entire package at the same time to prevent discrepancy in content and update it at least twice per year.
- To keep track of the most current version, use a naming convention or date-header that reflects the date of the most current version [i.e., don’t use the automatic date feature in your header].

Sample CV: Order of Content

Header with name, date [suppress on first page]

First Name Last Name, M.D., Ph.D.

Street Address
City, State zip code
(Area code) phone number
(Area code) fax number
email@address.com

Do NOT include SSN, age, gender, race, religion, political affiliation, marital/parental status, disability, or national origin.

Education

Fellowship, Your University, City, State 1996-1998
Residency, Your University, City, State 1992-1996
M.D., Your University, City, State 1988-1992
B.S. in Biochemistry (magna cum laude), Your University, City, State 1984-1988

List your educational history in reverse chronological order, including the name of the institution, city, state, degree earned, and year of completion or years of attendance.

Appointments

Associate Professor 2003-present
Department of
Your University
City, State

Consider moving this to the following

Director, Center for 1999-present
Your University

List your employment history in reverse chronological order.
<table>
<thead>
<tr>
<th>City, State</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assistant Professor</td>
</tr>
<tr>
<td>Department of</td>
</tr>
<tr>
<td>Your University</td>
</tr>
<tr>
<td>City, State</td>
</tr>
<tr>
<td>1996-2003</td>
</tr>
<tr>
<td>Chief Resident</td>
</tr>
<tr>
<td>Department of</td>
</tr>
<tr>
<td>Your University</td>
</tr>
<tr>
<td>City, State</td>
</tr>
<tr>
<td>1995-1996</td>
</tr>
</tbody>
</table>

### Other Positions and Employment

List non-academic employment history in reverse chronological order, noting position held, employer, location, and brief description of duties and responsibilities.

### Certification and Licensure

- Diplomate, Your ABMS Board
- Subspecialty Certification, Your Subspecialty Board
- State Medical License

### Professional Memberships and Activities

List your professional memberships, grouped by professional organization, in reverse chronological order, noting leadership positions and other positions held.

### Honors and Awards

- Golden Apple Award for Excellence in Teaching

### Committee Assignments and Administrative Services

List in reverse chronological order, noting leadership positions held. Include university and non-university activities (e.g., work with NIH study groups).

### Educational Activities

1. Identify your teaching activities here or write "See attached Teaching Portfolio"

Include only if it is an appointed position requiring an extension of the residency.

Include the state and year of licensure in reverse chronological order for all active then inactive licenses. Do NOT list DEA numbers.

This section may also include editorial activities. If, however, you have served as editor in many contexts, consider grouping these together under a separate heading, by publication, in reverse chronological order.

You may also list elite fellowship programs, those to which you were accepted on the basis of a competitive, as opposed to first-come, first-serve, application process.

If you do not refer to a separate
2. List in reverse chronological order, noting your role (course developer, course director, lecturer) and including applicable spans of time
3. Include supervision of doctoral students and thesis supervision in a research setting
4. Include graduate student teaching
5. Identify teaching residents in a clinical setting
6. Include advising responsibilities

Grants
1. List under sections of pending, current, and past grants in reverse chronological order
2. Include the title of grant
3. Identify the granting agency and grant number
4. Note the award total, demarcating total direct and indirect costs
5. State your role, also identifying the PI if you are not the PI, and percent of effort
6. Include the dates of award
7. If you include contracts, rename the section, "Grants and Contracts," and use two subheadings, separating contracts from grant awards.
8. If voluminous, truncate this listing to the most recent decade and note the limitation in the heading.

Patents
List these in CHRONOLOGICAL order to provide for easy updating.

Editorial Work
List these in reverse chronological order.

Abstracts and Presentations

**Oral Presentations**
National/International Meetings
Local/Regional Meetings

**Posters**
National/International Meetings
Local/Regional Meetings

Publications
1. List your publications in **chronological** order for easy updating
2. **Number** these and highlight your name in bold
3. Follow this **order** - peer-reviewed, non-
peer-reviewed publications, articles accepted for publication, books and monographs, evidence of works in progress (complete articles published in conference proceedings, book chapters, review articles, editorials as indicated), development and/or publication of educational materials, development of major curricular offerings or innovative educational programs, non-print materials, published abstracts

4. **Note:** if you’re not listed as first author on publications for which your mentored student is listed, note that role with an asterisk or other indicator

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### Educational Activities

<table>
<thead>
<tr>
<th>Clinical Teaching</th>
<th>[include a description of activities here]</th>
<th>[list year(s)]</th>
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<td>CME</td>
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<td>Course/Curriculum Development</td>
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<td>Educational Committees</td>
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### Research

### Pending Awards

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<th>Project Title</th>
<th>Project Period</th>
<th>Role and Percent of Effort</th>
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<td>[Funder - No.]</td>
<td>Description:</td>
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### Current Awards

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<th>Project Period</th>
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<td>[Funder - No.]</td>
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### Past Awards

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<th>Role and Percent of Effort</th>
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### Contracts

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<th>Contract Title</th>
<th>Contract Period</th>
<th>Role and Percent of Effort</th>
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<tr>
<td>[Funder]</td>
<td>Description:</td>
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Instructions for Completing the UAMS Educator's Portfolio

INTRODUCTION

The Criteria and General Guidelines for Faculty Appointments, Promotion, and Tenure in the School of Medicine at UAMS, lists the evaluation of faculty performance in Scholarship, Teaching, and Service as an essential part of the Promotion and Tenure Committee's responsibility in their recommendations to the Dean. Detailed and accurate information regarding these activities is essential for the maintenance of high standards for promotion and tenure and fair treatment of the faculty and the students who receive instruction from these faculty.

Research has come to be viewed as the first and most essential form of scholarly activity. Thus, scholars are considered to be only those academics who conduct research and publish their results in scholarly journals. There is a need, however, to expand the definition of scholarship to include the synthesis, application, and instructional aspects of new discovery.

Accurate evaluations of educational contributions by faculty of an academic institution should be a high priority. The first step in achieving this goal is to develop a method for gathering data about faculty educational contributions from various perspectives and to insure that this process is continuous. A well-designed Educator's Portfolio will accomplish this task and is essential if educational contributions by the faculty are to become an important part of their job description. The Educator's Portfolio is a collection of materials documenting educational activity and scholarship--like an artist's portfolio. Each of the sections represents a major arena in which faculty are likely to demonstrate contributions as educators. As faculty have different roles and responsibilities, the "picture" presented by the portfolio may vary. The common element is that the picture can be viewed, reviewed, updated, and valued as evidence of educational scholarship.

The purpose of this document is to assist faculty in preparing their material for promotion and tenure. It is a guide or checklist. Some of the sections in this document overlap with sections in a typical curriculum vitae (e.g., educational grants and publications). Where faculty choose to place this information will vary depending on the individual and what best describes their accomplishments. This document is meant to be comprehensive and provide faculty with extensive lists of examples. It is not expected that faculty will include all sections in their portfolios.

Finally, it is difficult for faculty to track the exact amount of time they spend in educational activities. The rough estimates requested in this document are just that. Appendices B and C are examples of ways that faculty may estimate the hours they spend in educational activities and summarize those estimates in tabular form for the Promotion and Tenure Committee. Some departments track this information for their faculty. Faculty may choose to do this themselves or add to the data already collected.

1 Adapted from the Educator’s Portfolio used at Oregon Health Sciences University. OHSU based sections of their portfolio on one from the University of Kentucky.
ORGANIZATION AND CONTENTS OF THE EDUCATOR’S PORTFOLIO

1. Overview of Your Role as an Educator

An overview introduces and frames your work. It should be an abstract directed to individuals not familiar with your work. You may use the questions listed in Appendix A as a guide. Where appropriate, provide descriptive examples. Please limit your overview to 500 words.

2. Scholarship

Please provide a list of your activities in the following areas.

a. Curriculum Development and Instructional Design

Scholarship, the development of new knowledge or ways of communicating knowledge (creative syntheses, new conceptualizations), will be demonstrated by the development of learning goals and the transformation of these goals into learning objectives, teaching methods, and methods of curriculum evaluation. Candidates who present evidence of scholarly activity in curriculum development will be responsible for developing, implementing, and evaluating new or substantially revised curricula, courses, experiential learning programs (e.g., clerkships), and seminars. Scholarship in instructional design may be demonstrated by the introduction of novel techniques and technologies for teaching and evaluation.

- Significant contributions to the development, implementation, and evaluation of curricula (including the development of field placement opportunities and experiential learning activities)
- Introduction of novel techniques for teaching and learning or evaluation

b. Educational Publications (list peer reviewed publications separately)

- Print media: textbooks, chapters, monographs, reviews, and original articles (include materials disseminated through electronic networks)
- Development and production of video/film/audio materials
- Computer-based learning materials

c. Educational Conference Presentations (list peer reviewed presentations separately and divide into international, national, regional, and local presentations)

- Reports, discussions, workshops, poster sessions, and demonstrations

3. Education Grants and Contracts
This includes grants and contracts in which you played a major role in their development and implementation. Please include a description of your role. (List by year and include dollar amounts.) Examples include:

- fellowship and post-doctoral training grants
- innovative educational projects
- primary care training grants
- faculty development grants
- program evaluation projects
- minority and high school student recruitment programs

4. Educational Activity

Summarize your educational activities in chart form. Include one chart for each year. A format for the chart and a sample worksheet for calculating the number of hours are appended (Appendix B and C, respectively).

Please list your activity in chronological order by 1) category of activity (e.g., teaching, mentoring/advising, administration) and 2) type of learner (e.g., graduate student, medical student, fellow), if appropriate. Provide an estimated number of hours per year in that activity. Document in the supporting materials how you arrived at these estimates. Indicate the number of actual contact hours and number of preparation hours in the supporting materials.

a. Teaching Activity (including testing and evaluation of learners)

Testing and evaluation activities should be included. Listed below are examples of the different types of learners you might have taught.

- high school and college students
- medical students
- graduate students/post-doctoral fellows
- residents
- fellows
- allied health students
- faculty development at UAMS
- continuing medical education (local, national, international)
- community/patient education
- other

b. Adviser/Mentor

Please include the following information if it is applicable.

- number and type of advisees (e.g., undergraduate and graduate students, medical students, fellows, junior faculty)
• nature and extent of advising (both formal and informal)
• list of masters and doctoral students for whom you serve on their thesis or advisory committees
• summary of activities and time commitment associated with student organizations and student-faculty committees

c. Educational Administration: Leadership and Service

(1) Administration of Educational Programs and Committees

• director of courses, clerkships, residencies, fellowships, graduate programs
• leadership of curriculum and course committees, admissions committee, ad hoc committees that advise on educational programs

(2) Service and Membership on Educational Committees (Include your role on the committee, for example, chair, member, etc.)

Examples of these activities include:

• medical school admissions committee (interviewers and members)
• graduate student and residency selection committees (interviewers and members)
• curriculum committee
• basic sciences, clinical sciences, and curriculum evaluation subcommittees
• student-faculty committees
• inter-departmental, departmental, and inter-institutional education committees (e.g., course and clerkship committees, ad hoc committees and task forces)
• education committees for UAMS and local, state, and national organizations
• accreditation committees

d. Effectiveness of Educational Activity

Please include data on the effectiveness of your educational activities. Listed below are examples of the type of data on effectiveness that you might include. These are organized by the three categories used for educational activities. Please develop a summary paragraph of these evaluations and have them available for review.

(1) Teaching Activity

• evaluations by learners
• evaluations by other faculty (peers)
• evaluations by course directors, chairs of curriculum committees
• indicators of learner performance (see section on advisor/mentor)
• self-evaluation

(2) Adviser/Mentor

• indicators of learner performance (e.g., remediation of students with academic problems, student academic awards, completion of thesis, career choice and career path of advisees)
• evaluations by chairpersons
• self-evaluation

(3) Evaluation of Administration and Service for Educational Programs

For leaders, chairs or directors, this may include evaluations by the

• committees that advises/assists the director
• faculty participating in the program
• curriculum committee and its subcommittees
• documentation of successful accreditation and/or recruitments

For members or participants, this may include evaluations by the director or chair of the committee or program (also see collaborative skills).

5. Honors and Awards for Education

List all departmental, medical school, university, state, and national honors and awards you have received for your work in the area of education.

6. Professional Development in Education

List local and national faculty development workshops and courses you attended and any individual work done on educational skills with the advice of peers, chairpersons, or educational specialists. Also, list sabbaticals taken to work on educational skills.

7. Additional Educational Activities
List any education related activities that were not listed in any of the above categories.
APPENDIX A

Preparing Your Overview Statement for the Educator’s Portfolio

The purpose of the questions that follow is to help you develop the overview of your role as an educator for your teaching portfolio. Where appropriate, provide descriptive examples.

1. What are your teaching responsibilities (classroom, laboratory, clinic, bedside)? What do you teach?

2. How do you teach? How would you describe your teaching style? Your teaching methods? What is the value to students of your teaching style?

3. Describe major projects, assignments, clinical experiences, or other activities used to support or help students learn. In what way did these activities foster student learning?

4. Provide specific examples of how you motivate your students to learn.

5. How would students describe you to other students? What would you like them to say?

6. How would students describe your availability to them? How do you let students know of your availability?

7. How do you maintain a current knowledge base in your discipline and change your courses to reflect that knowledge? How do you use your research or clinical practice to inform your teaching?

8. How do you assess your instructional efforts? Describe the information you collected and how the information influences your teaching.

9. Describe activities you have engaged in to enhance your teaching effectiveness.
   a. Workshops, conferences, or presentations attended related to teaching. For each activity, indicate who conducted it, the topic, and how it influenced your teaching.
   b. What reading have you done to enhance your teaching?

10. What are your future instructional goals or plans for enhancing your instructional activities?
APPENDIX B
Summary of Educational Activity and Effectiveness
Academic Year 20__ *

Percent time devoted to educational activities during this year _____% 

<table>
<thead>
<tr>
<th>Category of Educational Activity</th>
<th>Type of Learner</th>
<th>Your Activities</th>
<th>Average Number of Hours/Year</th>
<th>Effectiveness Documentation Included±</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teaching Activity</td>
<td>Adviser or Mentor</td>
<td></td>
<td>Contact Prep</td>
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<tr>
<td>Administration (including service on committees)</td>
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</table>

*Include one of these charts for each year.

±Please provide documentation of your effectiveness (e.g., average student, resident, and fellow ratings; letters from current or former graduate students; etc.) for the educational activity listed.
APPENDIX C

Sample Worksheet for Estimating the Number of Hours in Educational Activities

Please explain any situations or calculations that may be atypical in estimating the number of hours spent in educational activities.

A. Teaching activities

1. Lectures and small group seminars

   ___ Direct contact hours
   ___ 1 - 5 hours preparation time for each hour of a new lecture/seminar
   ___ 1 hour preparation time for each hour of an old lecture/seminar

2. Clinical teaching or teaching in the laboratory setting

   For purposes of this document, list actual number of hours spent in the clinic or laboratory with students, residents, or fellows as teaching hours.

3. Evaluation activities

   Actual number of hours observing students, writing test questions, proctoring exams, etc.

B. Advising or mentoring

   Number of direct contact hours should be used.

C. Administrative activities

   Actual number of hours.
I. INITIAL APPOINTMENTS

A person who received an initial appointment to a given rank should have credentials and experience equivalent to individuals promoted to the same rank. A doctoral degree or appropriate professional experience is a necessary qualification for appointment to faculty status at Assistant Professor or above. Initial appointments at the rank of Associate or Full Professor will be reviewed by the Promotions and Tenure Committee. A matrix system will be used to estimate the approximate faculty effort in each of the three main areas of academic endeavor - i.e., teaching, research and service. A tenure track appointment implies a commitment to exemplary teaching on the part of all faculty, regardless of pathway. The level of activity in research and clinical service largely influences the assignment to a given pathway. The chart below illustrates the matrix concept depicting examples and ranges of effort of the different pathways.

### COMPENSATED TRACKS

<table>
<thead>
<tr>
<th>Pathway</th>
<th>Tenure Track</th>
<th>Non Tenure Track</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Basic Scientist</td>
<td>Clinical Scientist</td>
</tr>
<tr>
<td>TEACHING</td>
<td>30%10 - 35%</td>
<td>30%10 - 50%</td>
</tr>
<tr>
<td>RESEARCH</td>
<td>60%50 - 85%</td>
<td>30%15 - 85%</td>
</tr>
<tr>
<td>SERVICE</td>
<td>10%5 - 35%</td>
<td>40%5 - 75%</td>
</tr>
</tbody>
</table>

The goal of clinical departments should be to have the majority of tenured and untenured faculty in the Clinical Scientist pathway. Faculty from the AHEC will usually be Clinician-Educators and will not be included in departments for purposes of the calculations described above. The numbers and types of faculty positions assigned to the Clinical Educator and Clinical Attending pathways in each department will be determined by the needs of the College of Medicine and the department. Based upon these needs, individuals who fulfill departmental criteria may be appointed in specific available positions to the Clinical Educator pathway with the approval of the Dean of the College of Medicine. The Clinical Attending and Research Scientist pathways are non-tenure track pathways. Therefore, appointments to the Clinical Attending and Research Scientist pathways are made on an annual basis and carry with them no tenure commitment from the University. Before the time of appointment, the Departmental Chair will meet with each faculty member to negotiate and record his or her responsibilities, expectations, and career goals. These deliberations will determine the appropriateness of assignment of a faculty member to a position in any particular pathway. Once appointed, clinical faculty may switch between the clinical scientist and clinical educator pathways (with approval of the respective department chair and the Dean) during the first
36 months of service. Additionally, with approval of the respective department chair and the Dean, faculty appointed to a tenure-track position may change to a non-tenure track. Similarly, under unusual circumstances and with the approval of the respective chair and the Dean, faculty appointed in a non-tenure track may, prior to 6 years of service, switch to the tenure track provided that each year of service in the non-tenure track shall count as one year of probationary status under the tenure track. A faculty member can only make a single change between tenure track and non-tenure track. An individual who has switched to a non-tenure pathway may not return to a tenure pathway. The Dean’s decision with regard to changes in pathways and tracks shall be final, subject to the usual appeals mechanisms.

II. REAPPOINTMENTS AND PROMOTIONS
Reappointment of non-tenured faculty to a given rank requires that the individual meet the requirements of that rank and show good year-to-year performance in teaching, research and service as appropriate for the particular pathway to which he/she is assigned. To be considered for promotion, the faculty member must have the qualifications for the next rank. It is possible to be a valuable faculty member at a certain rank or many years without demonstrating sufficient progress to merit promotion.

A. INSTRUCTOR

The rank of Instructor is appropriate for qualified individuals who have limited experience in teaching, research and service. Faculty may be advanced from Instructor to the rank of Assistant Professor in either the Tenure or Non-Tenure track at the request of the Departmental Chair with the approval of the Dean. While serving as an Instructor, a person is expected to demonstrate significant professional growth, as evidenced by active involvement in the following:

1. Instructors who are basic scientist are expected to apply for research support within the period of this appointment. The application can be for institutional general research support and/or a research grant from an external source, such as one of the federal agencies.

2. Instructors who are clinicians are expected to contribute actively to the teaching program, to develop improved clinical skills and to become involved in original research, or to support and participate in ongoing institutional research.

B. TENURE TRACK

1. ASSISTANT PROFESSOR

An initial appointment of Assistant Professor may be offered to individuals who have the qualifications for that rank.

While serving as an Assistant Professor, an individual is expected to demonstrate significant development as an academician evidenced by the criteria listed below.

a. Teaching Ability. Satisfactory teaching is basic for appointment and reappointment at the Assistant Professor rank. Effort and progress toward becoming an excellent teacher must be demonstrable, with consideration given to innovative teaching. Shared teaching in other departments and in other UAMS colleges, when approved by the Chairman, will be equated with instructional
activities in the department of primary appointment. Documented evaluation of the quality of an individual’s teaching performance is the responsibility of the Chairman, who should seek the counsel of other faculty members and students.

The teaching ability of the basic scientist is demonstrated in lectures, laboratory instruction, small group seminars, and individual tutorials for medical and graduate students. Participating in the affairs of the graduate faculty is also expected of a basic scientist at the Assistant Professor level. The clinical faculty member is evaluated on the supervision of students, housestaff and fellows, and the dedicated and effective teaching in clinical rounds, conferences, lectures, and individual tutorial sessions.

b. **Research Performance.** An Assistant Professor is expected to develop a research program and to publish scientific papers in peer-reviewed journals. Assistant Professors in the basic scientist pathway should develop sufficient extramural funding to support their research activities. Assistant Professors in the clinical scientist pathway are expected to secure adequate funding for their independent research through extramural research grants, service contracts, and/or through the development of a clinical practice. Research is also encouraged for Assistant Professors in the clinician-educator pathway, who should support and participate in ongoing institutional research initiatives.

c. **Service (Clinical, Administrative).** To be appointed at the Assistant Professor level, all clinical faculty (clinical scientists and clinical-educators) must have demonstrated excellent skills in patient care and should receive the strong endorsement of their departmental chairman. Skilled patient care is of such basic importance that it must be considered a condition for annual reappointment for all clinicians.

Service on departmental and institutional committees is expected of an Assistant Professor in each of the academic pathways.

d. **Professional Recognition.** Assistant Professors in all pathways will seek and maintain membership in appropriate professional societies and organizations. They will also continue their own professional education and where appropriate, will seek advanced certification or other such special qualifications. Basic and clinical scientists should be developing a regional and national reputation.

2. **ASSOCIATE PROFESSOR**

Promotion to the rank of Associate Professor is considered to be a very important step for both the University and the faculty member. It would be unusual for a person to be promoted to Associate Professor with less than five years experience at the Assistant Professor rank. A significant degree of maturity as a scientist, teacher and/or clinician must be clearly evident before promotion will be considered.
a. **Teaching Performance.** Exemplary teaching is an important consideration for appointment at the Associate Professor level. The faculty member should have assumed increased responsibility in departmental teaching programs. Examples of such increased responsibilities for basic science faculty include directing graduate seminars, service as a graduate or medical student course leader, teaching outside one’s own area of special interest, and serving as a major advisor on thesis and dissertation committees. Clinical faculty members should exhibit expertise in teaching activities such as conducting high quality patient rounds, conferences and lectures. Evaluation as to whether an individual performs in a manner appropriate for an Associate Professor is the responsibility of the Departmental Chairman, who should obtain the counsel of the faculty and students. The relative weight of teaching performance in a decision to appoint or to promote to Associate Professor will depend on the role of the individual faculty member in the department.

In accordance with faculty policy on evaluation of teaching (as approved by the general faculty, Spring, 1986 and June, 1987) evaluation of teaching performance, where appropriate, should be obtained from medical students, housestaff, fellows, graduate students and peers. Evidence of teaching contribution should include the number of local teaching initiatives and contact hours (seminars, lectures, clinical case conferences, grand rounds) for which the faculty member was responsible. In addition, evidence of community education activities as well as participating in local, regional and national educational programs, if documented, will favor promotion. It is the combined responsibility of the Departmental Chairman and the individual faculty member to assure that teaching skills are appropriately evaluated and that an accurate record of teaching contributions is kept.

b. **Research Performance.** Research and scholarly achievement are integral features of academic life and are important criteria for appointment or advancement to the rank of Associate Professor. Productivity in research and scholarly activity is demonstrated by the publication of scientific articles and participation in national and/or international scientific meetings. Quality of the research and independence of scholarship as judged from the papers is more important than the number of papers.

The ability to generate and sustain financial support for research is an important consideration for promotion to Associate Professor. Basic scientist candidates for promotion to Associate Professor should have been either a principal investigator or a co-investigator in one or more research grants from an extramural agency employing the peer review process. This is to provide evidence of the candidate’s ability to develop a good research project, prepare acceptable applications, and obtain general support. An NIH Research Career Development Award or an award of similar stature from other agencies or national foundations will be counted as a research grant, but Institutional General Research Support grants for pilot studies will not be counted.
Clinical scientist candidates for promotion to Associate Professor must have developed skills which support their independent research either through clinical practice or research grants.

Basic and clinical scientist candidates for promotion to the Rank of Associate Professor should submit copies of their five most meritorious publications for consideration by the Promotion and Tenure Committee. Clinical Educators are also encouraged to submit evidence of their scholarship. In order that a publication be given weight for promotion, it must be published or “in press”. A candidate should be the senior author on a number of publications. The publication of these papers alone does not insure promotion. Most important is evidence of continuing, productive, independent and mature scholarship.

c. **Service (Clinical, Administrative).** In addition to teaching and research, a person nominated for promotion to Associate Professor is expected to have shared in the service load for departmental and university programs.

For faculty in both clinical tracks, diligence and excellence in the care of patients are central considerations for appointment or promotion to Associate Professor. Within clinical departments, the time commitment to patient care activities will vary, but will frequently average 50% or more of the total available effort. The assessment of clinical productivity will be based on an evaluation by the Departmental Chairman.

Evidence must be presented attesting to the clinical skills of the clinical faculty member, as evidenced by respect for this competence by academic and community physicians with whom the faculty member works. Clinical competence should be addressed by supporting letters from the Departmental Chairman and from faculty members within the division and the College of Medicine.

For basic scientists, service may be assessed by reviewing the type and complexity of committee work or administrative role. Clinicians should assume appropriate administrative activities in the affiliated hospitals and the College of Medicine. Evidence of participation and documentation of substantive valuable contributions should be included. Chairmanships of committees, or other evidence of active involvement in administration is important and should be documented.

d. **Professional Recognition.** Basic and clinical scientists eligible for appointment or for promotion to Associate Professor should have established a reputation in the national or international medical/scientific community. In addition to research productivity, reputation is judged by such evidence as participation in appropriate professional organizations and presentations before national and/or international meetings. Additionally, board certification in the appropriate discipline, and, where appropriate, subspecialty certification is expected for promotion to Associate Professor. Candidates considered for promotion to Associate Professor should have at least two letters of recommendation obtained by the Chairman from...
recognized national authorities in a candidate’s special field of interest not involved in prior training or employment. Other letters of recommendation are encouraged.

e. **Faculty Vote.** A non-binding vote by secret ballot of the Associate and Full Professors in the candidate’s department is recommended for those individuals being considered for promotion to Associate Professor. An alternative is a departmental promotions committee which would judge the readiness of the candidate for promotion. The departmental chair (or division director in cases where the division director reports directly to the Dean) will retain the authority to nominate the candidate. The results of any departmental or committee vote should be made available to the Promotion and Tenure Committee.

3. **PROFESSOR**

Promotion to the rank of Professor is a high honor of the University and is reserved for those members of the faculty who have demonstrated outstanding ability. It is not based on length of service alone. Candidates should meet all of the criteria outlined for the rank of Associate Professor. Additionally, they should have considerable time and experience in rank, additional publications, and provide other evidence of scholarly activity and professional recognition.

a. **Teaching Ability.** The teaching performance of a candidate for Professor should serve as a standard of excellence for colleagues. Professors are expected to be accomplished teachers, and should be willing to share with less experienced faculty some of their learned skills in the art of medical and graduate education.

b. **Research Performance.** The quality of research and of the resulting publications is the most important criterion of research performance. The candidate should have demonstrated independent and outstanding ability in research. Basic and clinical scientist candidates for promotion to the rank of Professor should submit copies of their ten most meritorious publications for review by the Promotion and Tenure Committee. Clinician candidates for promotion to Professor should provide evidence of their scholarship by submitting copies of their publications in peer-reviewed journals. The publication of these papers alone does not insure promotion. Most important is evidence of continuing, productive, independent and mature scholarship.

Continuing and current research support is important for promotion to Professor. A basic scientist candidate should have obtained at least two extramural research grants or have had a single grant renewed before attainment of the rank of Professor. The clinical scientist should have a similar record of extramural grant support or have generated support from clinical service activities for his or her independent scholarly work. The clinician should have a record of collaboration in investigations supported by extramural grants or clinical service activity.
c. **Service, (Clinical, Administrative)** In addition to teaching and research, a person nominated for promotion to Professor is expected to have assumed a leadership role in the service load for departmental and university programs.

For faculty in both clinical pathways, appointment or promotion to the rank of Professor requires a demonstrated leadership and excellence in the care of patients. Within clinical departments, the time commitment to patient care activities will vary, but will frequently average 50% or more of the total available effort. The assessment of clinical productivity will be based on an evaluation by the Departmental Chairman.

Evidence must be presented attesting to the clinical skills of the clinical faculty members, as evidenced by respect for this competence by academic and community physicians with whom the faculty member works. Clinical competence should be addressed by supporting letters from the Departmental Chairman and from faculty members within the division and the College of Medicine.

For basic scientists, service of candidates for appointment or promotion to the rank of Professor is characterized by an increased complexity committee work or administrative role. Clinicians should assume appropriate administrative activities in the affiliated hospitals and the College of Medicine. Evidence of participation and documentation of substantive valuable contributions should be included. Chairmanships of committees, or other evidence of active involvement in administration is important and should be documented.

d. **Professional Recognition.** Recognition among peers is very important for candidates for the rank of Professor. At least three letters of reference must be obtained by the Chairman and submitted to the Dean of the College of Medicine prior to the decision to promote the faculty member to this senior rank. Letters for basic and clinical scientists should come from outside the institution and from recognized authorities in the candidate’s special field of interest not involved in prior training or employment. This is not to suggest that letters from people who know the candidate well will not also be considered.

Professional recognition will also be judged on the basis of scholarly articles, reviews and books written by the candidate. Other manifestations of outstanding performance include serving in a major administrative role in the College of Medicine, service on the study sections of federal granting agencies, offices or committee membership in national scientific organizations, service on editorial boards of scientific journals, and special recognition awards for distinguished achievement.

d. **Faculty Vote.** A non-binding vote by secret ballot of the Full Professors in the candidate’s department is recommended for those individuals being considered for promotion to Full Professor. An alternative is a departmental promotions committee which would judge the readiness of the candidate for promotion. The
departmental chair (or division director in cases where the division director reports directly to the Dean) will retain the authority to nominate the candidate. The results of any departmental or committee vote should be made available to the Promotion and Tenure Committee.

4. **EMERITUS STATUS**

Faculty retiring after distinguished service may be accorded emeritus status. This status is not routinely awarded but represents an honor for a career characterized by the highest academic abilities and devotion to the advancement of the College of Medicine.

B. **NON-TENURE TRACK**

1. **RESEARCH SCIENTIST PATHWAY**

   a. **RESEARCH ASSISTANT PROFESSOR**

   In this nontenure track, research is of primary importance, and teaching and service are of secondary consideration in reappointment or promotion. Salary will customarily be derived from external support.

   (1) **Research Performance.** A Research Assistant Professor in the non-tenure Research Pathway is expected to contribute in a significant manner, generally as a collaborator, to a funded research program and to publish scientific papers in peer-reviewed journals. Research Assistant Professors are also encouraged to secure their own extramural funding.

   (2) **Professional Recognition.** Research Assistant Professors will seek and maintain membership in appropriate professional societies and organizations. They will also continue their own professional education and where appropriate will seek advanced certification or other such special qualifications.

   b. **RESEARCH ASSOCIATE PROFESSOR**

   Five years of experience as Research Assistant Professor are ordinarily required. Criteria for promotion to Research Associate Professor will be almost entirely based upon research performance.

   (1) **Research Performance.** Research and scholarly activity are considered to be the major criteria for promotion in the non-tenure Research Scientist Pathway. Consequently, to be promoted to the rank of Research Associate Professor in the non-tenure pathway, the faculty member is expected to have
been a significant collaborator on a successful research program. The
candidate is also expected to have demonstrated a degree of independence
through efforts to obtain independent research funding and scholarly activity.
Scholarly activity is demonstrated by the publication of scientific articles and
participation in national and/or international scientific meetings. As in the
tenure track pathways, the quality of such publications is more important than
the absolute number of papers. Candidates for promotion to the rank of
Research Associate Professor should submit copies of their five most
meritorious publications for consideration by the Promotion and Tenure
Committee. Ideally, the candidate should be the senior author on a number
of publications. The publication of these papers alone does not insure
promotion. Most important is evidence of continuing productivity and an
increasing maturity in scholarship.

(2) Professional Recognition. Candidates for promotion to Research Associate
Professor should have established a reputation in the national or international
scientific community. In addition to research productivity, reputation will be
judged by participation in and presentations before national and/or
international meetings and membership in appropriate scientific societies.
Candidates considered for promotion to Research Associate Professor should
have at least two letters of recommendation obtained by the Chairman of the
Candidate’s department from recognized national authorities in the
candidates special field of interest not involved in prior training or
employment. Other letters are encouraged.

(3) Faculty Vote. A non-binding vote by secret ballot of the Associate and Full
Professors in the candidate’s department is recommended for those
individuals being considered for promotion to Research Associate Professor.
An alternative is a departmental promotions committee which would judge
the readiness of the candidate for promotion. The departmental chair (or
division director in cases where the division director reports directly to the
Dean) will retain the authority to nominate the candidate. The results of any
departmental or committee vote should be made available to the Promotion
and Tenure Committee.

c. **RESEARCH PROFESSOR**

The title of Research Professor is an honor conferred on those who have
demonstrated outstanding performance as a Research Associate Professors over a
long period and whose activities are considered vital to a particular research
emphasis of the College of Medicine. Criteria for promotion to Research Professor
are the same as those of the Basic Scientist pathway in terms of research
performance. The title may also be accorded to distinguished senior investigators
recruited to the campus.
(1) **Faculty Vote.** A non-binding vote by secret ballot of the Full Professors in the candidate’s department is recommended for those individuals being considered for promotion to Research Professor. An alternative is a departmental promotions committee which would judge the readiness of the candidate for promotion. The departmental chair (or division director in cases where the division director reports directly to the Dean) will retain the authority to nominate the candidate. The results of any departmental or committee vote should be made available to the Promotion and Tenure Committee.

d. **EMERITUS STATUS**

Faculty retiring after distinguished service may be accorded the title of Emeritus Research Professor. This is a distinct honor that is not routinely awarded, but instead is reserved for those individuals whose devotion to research goals of the College have resulted in significant contributions over their careers.

2. **CLINICAL ATTENDING PATHWAY**

a. **CLINICAL ASSISTANT PROFESSOR**

The individual should be certified by the appropriate Specialty Board approved by the American Board of Medical Specialties or equivalent organizations and should show likelihood of developing an independent practice of his/her particular specialty. As this is a clinical nontenure track, research and teaching performance are not of primary importance in reappointment or promotion.

(1) **Clinical Performance.** To be appointed at the Clinical Assistant Professor level, faculty in the non-tenure Clinical Attending Pathway must have demonstrated excellent skills in patient care and should receive the strong endorsement of their departmental chairman. Skilled patient care and the ability to maintain clinical productivity is of such basic importance that it must be considered a condition for annual reappointment.

(2) **Professional Recognition.** Clinical Assistant Professors in this pathway will seek and maintain membership in appropriate professional societies and organizations. They will also continue their own professional education and where appropriate, will seek advanced certification or other such special qualifications.

b. **CLINICAL ASSOCIATE PROFESSOR**

At least five years of experience at the Clinical Assistant Professor rank are ordinarily required prior to promotion to Clinical Associate Professor. During
those years the faculty member should have developed an independent, exemplary practice of a medical, surgical or support specialty.

(1) **Clinical Performance.** Diligence and excellence in the care of patients are the sole considerations for promotion or appointment to Clinical Associate Professor in this pathway. For promotion, evidence must be presented attesting to the clinical skills and productivity of the Candidate, as evidenced by respect for this competence by academic and community physicians with whom the Candidate works. Clinical competence should be addressed in the Chair’s supporting letter.

(2) **Professional Recognition.** Candidates for appointment or promotion to Associate Clinical Professor should have established a reputation for their clinical skills in the local and national medical community. Additionally, the Candidate should have appropriate specialty and subspecialty board certification(s), and should be a member of, and participate in appropriate professional organizations. Candidates for promotion or appointment to Clinical Associate Professor should have at least two letters of recommendation obtained by the Chairman of the Candidate’s department from College of Medicine faculty not involved in the Candidate’s prior training. These letters should attest to the Candidate’s delivery of quality clinical care, the degree of clinical productivity and the degree of professional recognition within the medical community.

(3) **Faculty Vote.** A non-binding vote by secret ballot of the Associate and Full Professors in the candidate’s department is recommended for those individuals being considered for promotion to Clinical Associate Professor. An alternative is a departmental promotions committee which would judge the readiness of the candidate for promotion. The departmental chair (or division director in cases where the division director reports directly to the Dean) will retain the authority to nominate the candidate. The results of any departmental or committee vote should be made available to the Promotion and Tenure Committee.

c. **CLINICAL PROFESSOR**

The title of Clinical Professor is an honor conferred on those who have demonstrated a consistent and high level of practice activities over the span of many years. As such, it is customarily reserved for those senior individuals whose practice activities have been considered vital to the development of academic and educational programs over many years. An example would be individuals who have developed national or international referral patterns to their practice. The title may also be accorded to distinguished senior physicians recruited to the campus.
Faculty Vote. A non-binding vote by secret ballot of the Full Professors in the candidate’s department is recommended for those individuals being considered for promotion to Clinical Professor. An alternative is a departmental promotions committee which would judge the readiness of the candidate for promotion. The departmental chair (or division director in cases where the division director reports directly to the Dean) will retain the authority to nominate the candidate. The results of any departmental or committee vote should be made available to the Promotion and Tenure Committee.

d. EMERITUS STATUS

Faculty retiring after distinguished service may be accorded the title of Emeritus Professor in the Clinical Attending Pathway. This is a distinct honor that is not routinely awarded but is instead reserved for those whose devotion to and abilities in the practice of medicine have made the most significant contributions to the College of Medicine over their career.

C. VOLUNTARY NONCOMPENSATED TRACKS

1. ADJUNCT (BASIC SCIENTIST) PATHWAY

Candidates for appointments and promotions in the Voluntary (Basic Scientist) Pathway should satisfy the same high standards of scholarship as full-time members of the faculty in the Basic Scientist Pathway. The list of adjunct faculty will be reviewed yearly. Continuation of appointment will require sustained participation in the academic program of the Department and adherence to the ethical and professional standards.

2. ADJUNCT (CLINICAL) PATHWAY

Criteria for initial appointment of voluntary clinical faculty (Little Rock campus or AHEC) include willingness to provide personal time and effort on a regular basis in one or more of the academic programs of the College of Medicine. The voluntary faculty are expected to participate in the formal courses or programs of the department of primary appointment in such frequency and type of endeavor as approved by the Departmental Chairman. Attendance and participating in regular departmental conferences and meetings is encouraged.

a. Reappointment. The list of adjunct clinical faculty will be reviewed yearly. Continuation of appointment will require sustained participation in the academic program of the Department and adherence to the ethical and professional standards expected of physician-educators or community leaders.

b. Promotion. Service to the respective Department and the College of Medicine is a major consideration for promotion; however, advancement of the practice and science of medicine is also important. The latter may be documented either by publications in local or national journals, or by scientific presentations at meetings.
Continued exemplary teaching will be especially valued in the consideration for promotion. The rank of Adjunct Clinical Professor is reserved for those few physicians who have provided consistent and unquestioned leadership in the medical community, and who have maintained a strong supportive effort on behalf of the Department and/or College.

III. TENURE

Faculty tenure is the right of continuous appointment, subject to Board of Trustees Policy 405.1. Only full-time faculty in the tenure eligible academic pathways with ranks of Assistant Professor, Associate Professor, Professor, and Distinguished Professor are eligible to be awarded tenure. Individuals in the Non-tenure Compensated, as well as voluntary non-compensated pathways are not eligible to acquire tenure.

The granting of tenure implies that the individual has completed successfully his or her probationary period and has become a permanent member of the University community. As such, he or she has acquired additional procedural rights in the event that dismissal proceedings may be filed.

The probationary period may not extend beyond seven years except as specifically provided herein. An initial appointment of one-half-year (academic or fiscal) or less will not be included in the probationary period. An initial appointment of more than one-half of a year counts as one full year for the probationary period. If more than one-half of any year is spent in an off-campus duty assignment, or less than a full-time appointment, or in leave of absence without pay status, that year shall not apply toward the probationary period.

During the first six years of the probationary period, a tenure-track faculty member may request, for reasons set forth below, that the probationary period be extended by one (1) year. The reasons for such a request are the same required under the Family and Medical Leave Act of 1993 and are as follows: (a) the birth of a child to the faculty member or his spouse and its care during the first year; (b) the adoption of a child by the faculty member or placement in the faculty member’s home of a foster child; (c) the care of the faculty member’s spouse, child, or parent with a serious health condition; (d) the serious health condition of a family member.

A request to extend the probationary period for these reasons shall first be directed in writing to the Departmental Chair for approval and must also be approved by the Promotion and Tenure Committee, the Dean, the Chancellor, and the President, under such procedures as the President shall adopt. These procedures may include, but shall not be limited to, the manner in which the faculty member’s duties and salary, if any, are determined during such year, the information which is required to substantiate a request and the extent to which a faculty member’s performance during such year may be considered in awarding tenure. An individual who has already received a written notice of non-reappointment as defined in Board Policy 405.1, paragraph IV. B, may not be granted an extension in the probationary period.

As a general rule, the Chairman may recommend tenure for faculty appointed at the rank of Associate Professor or Professor in any of the tenure track pathways during the third year of faculty service, so that full tenure rights will begin with the fourth appointment. The range of tenure review consideration may, however, on occasion extend up to the maximum period of probationary service. Upon the recommendation of the department chairperson, after consultation with the departmental faculty and the concurrence of the
dean, chief academic officer, and chief executive officer of the campus, new appointees at the rank of associate professor, professor, distinguished professor, or University professor may be granted immediate tenure.

Tenure generally will not be awarded faculty at the Assistant Professor rank, and the seventh appointment will be a terminal appointment. In special circumstances, the Chairman may request special tenure consideration for such a faculty member during the seventh academic year.

Guidelines regarding tenure are found in Board Policy 405.1 (revised 1/1/81), included in the UAMS Faculty Handbook, 1996 edition, pp F.10-F.13.

The academic year begins July 1 and ends on June 30. Appointments made effective January 1 or later are considered one-half year or less for purposes of probationary year accrual.
Template for UAMS Educator’s Portfolio

1. Overview of Your Role as an Educator (Please limit your overview to 500 words.)

2. Scholarship (Please provide a list of your activities in the following areas.)
   
   a. Curriculum Development and Instructional Design

   b. Educational Publications (List peer reviewed publications separately.)

   c. Educational Conference Presentations (List peer reviewed presentations separately and divide into international, national, regional, and local presentations.)

3. Education Grants and Contracts

   This includes grants and contracts in which you played a major role in their development and implementation. Please include a description of your role. (List by year and include dollar amounts.)

4. Educational Activity

   Please include a copy of Appendix B for each year.

5. Honors and Awards for Education (Please list.)
6. **Professional Development in Education** (Please list.)

7. **Additional Educational Activities** (List any education related activities that were not listed in any of the above categories.)
APPENDIX A

Preparing Your Overview Statement for the Educator’s Portfolio

The purpose of the questions that follow is to help you develop the overview of your role as an educator for your teaching portfolio. Where appropriate, provide descriptive examples.

1. What are your teaching responsibilities (classroom, laboratory, clinic, bedside)? What do you teach?

2. How do you teach? How would you describe your teaching style? Your teaching methods? What is the value to students of your teaching style?

3. Describe major projects, assignments, clinical experiences, or other activities used to support or help students learn. In what way did these activities foster student learning?

4. Provide specific examples of how you motivate your students to learn.

5. How would students describe you to other students? What would you like them to say?

6. How would students describe your availability to them? How do you let students know of your availability?

7. How do you maintain a current knowledge base in your discipline and change your courses to reflect that knowledge? How do you use your research or clinical practice to inform your teaching?

8. How do you assess your instructional efforts? Describe the information you collected and how the information influences your teaching.

9. Describe activities you have engaged in to enhance your teaching effectiveness.
   a. Workshops, conferences, or presentations attended related to teaching. For each activity, indicate who conducted it, the topic, and how it influenced your teaching.
   b. What reading have you done to enhance your teaching?

10. What are your future instructional goals or plans for enhancing your instructional activities?
**APPENDIX B**

Summary of Educational Activity and Effectiveness

Academic Year 20__*

Percent time devoted to educational activities during this year ______% 

<table>
<thead>
<tr>
<th>Category of Educational Activity</th>
<th>Type of Learner</th>
<th>Your Activities</th>
<th>Average Number of Hours/Year</th>
<th>Effectiveness Documentation Included±</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Contact</td>
<td>Prep</td>
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<tr>
<td>Teaching Activity</td>
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<tr>
<td>Adviser or Mentor</td>
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<tr>
<td>Administration (including service on committees)</td>
<td>Your Role (on committees)</td>
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</tbody>
</table>

*Include one of these charts for each year.

±Please provide documentation of your effectiveness (e.g., average student, resident, and fellow ratings; letters from current or former graduate students; etc.) for the educational activity listed.
APPENDIX C

Sample Worksheet for Estimating the Number of Hours in Educational Activities

Please explain any situations or calculations that may be atypical in estimating the number of hours spent in educational activities.

A. Teaching activities

1. Lectures and small group seminars
   - Direct contact hours
   - 1 - 5 hours preparation time for each hour of a new lecture/seminar
   - 1 hour preparation time for each hour of an old lecture/seminar

2. Clinical teaching or teaching in the laboratory setting

   For purposes of this document, list actual number of hours spent in the clinic or laboratory with students, residents, or fellows as teaching hours.

3. Evaluation activities

   Actual number of hours observing students, writing test questions, proctoring exams, etc.

B. Advising or mentoring

   Number of direct contact hours should be used.

C. Administrative activities

   Actual number of hours.
Promotion and Tenure Committee Cover Page

Name: Your Name Here
Highest Academic Degree:
Initial UAMS appointment (mm/dd/yy):
Initial Rank
Current Rank
Effective date (mm/dd/yy)
Requested Change

Track and Pathway: (check the appropriate box)
Track: □ Non tenure □ Tenure
□ Basic Scientist □ Clinical Educator □ Clinical Scientist
□ Clinical Attending □ Research Scientist
Voluntary Noncompensated Track: □ Adjunct (Basic Science) □ Adjunct (Clinical)
Allocation of percent effort:
Teaching Research Patient Care Administration
% % % %

Table of Contents
Please note it is not necessary to retype the candidate's curriculum vitae. Page numbers may refer to pages in candidate's curriculum vitae by indicating cv after the number.

<table>
<thead>
<tr>
<th>Section</th>
<th>Page(s)</th>
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<tbody>
<tr>
<td>Letter of support from primary department appointment</td>
<td></td>
</tr>
<tr>
<td>Letter of support from secondary department appointment (when appropriate)</td>
<td></td>
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<tr>
<td>Chronology of academic training</td>
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<tr>
<td>Chronology of professional experience:</td>
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<tr>
<td>Teaching Documentation:</td>
<td></td>
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<td>Teaching responsibilities:</td>
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<td>Evaluation of teaching:</td>
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<td>Extramural Research Support:</td>
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<td>Past extramural research support</td>
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<tr>
<td>Current (active) extramural research support:</td>
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<tr>
<td>Chronological listing of publications:</td>
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<td>Peer-reviewed publications:</td>
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<td>Review articles</td>
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<td>Case reports:</td>
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<td>Abstracts:</td>
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<td>Other publications:</td>
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<td>Documentation of patient care:</td>
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<td>Documentation of administrative and service responsibilities:</td>
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<td>Evidence of professional recognition:</td>
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<td>Professional society memberships and elected offices</td>
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<td>Editorial board assignments:</td>
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<td>Study sections</td>
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<td>Noteworthy presentations</td>
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<td>Other:</td>
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<tr>
<td>Letters of Recommendation</td>
<td></td>
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<tr>
<td>Appendix material (representative publications, etc.)</td>
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</tbody>
</table>

Revised: 6/6/05
Tips for Preparing Your Promotion and Tenure Packet

Binders for your P/T Packet:
- Binders must securely hold all the papers and be as compact as possible to save trees and the Promotion and Tenure Committee.
- Packets can be 3 ring binders (soft or hard cover), spiral binders, Ecco binders, heavy-duty stapled, but the binders should allow you to add or subtract at the last minute.
- Do not use “clasp” binders if they are not strong enough to firmly hold papers when held upside down.

Labels on Binders:
- Clearly label each packet with “your name, degree” candidate for what pathway, tenure candidate or not, and the date.” For example, “Jane R. Lightfoot, M.D., Candidate for Associate Professor of Pathology with tenure in the Clinical Educator Pathway, October, 2005.”
- For Basic Scientists and Clinical Scientists, four (4) packets should contain publications and should be clearly marked as the publication packets.

Number of Reprints:
- For Basic Science and Clinical Science Associate Professors, include five (5) of your most meritorious reprints in the 4 labeled packets.
- For Basic Science and Clinical Science Professors, include ten (10) of your most meritorious reprints (particularly those since your last promotion) in the 4 labeled packets.
- Clinical Educators are encouraged to submit scholarly publications at both the Professor and Associate Professor level although the Promotion and Tenure document does not stipulate how many.

Number of Outside Letters of Recommendation:
- The Department Chair should solicit letters of recommendation for the candidate.
- Letters of recommendation should be returned to the Chair.
- The person writing the recommendation should hold a higher academic rank that that being requested.
- For Associate Professor, a minimum of two (2) letters are required and a maximum of four (4) letters can be obtained from recognized national authorities at the Professor level who have not been involved in the previous training or employment of the candidate.
- For Professor, a minimum of three (3) letters are required and a maximum of four (4) letters can be obtained from recognized national authorities at the Professor level who have not been involved in previous training or employment of the candidate.

Number of Packets:
- 18 copies of your Promotion and Tenure packets are due Monday, October 3, 2005 no later than 4 pm firm.
- Deliver them to the Office of Faculty Affairs (4D40 - University Hospital).
- Ms. Connie Albert is the Promotion and Tenure contact for processing the packets (526.4684).
- If possible, deliver packets early.
- Candidates should ALWAYS keep the original packet.

Basic tips:
- Divider tabs marking major sections help committee reviewers find relevant information. Organize the tabs according to the Promotion and Tenure cover sheet.
- Make a cover sheet and a spine label for the binder packets with name, candidate for... and date.
- You can have an appendix at the end of the packet with more information that the committee may or may not refer to.
- Less is often more. When possible summarize your activities. Show how your teaching evaluation summaries compared to departmental summaries.

Secondary Appointments:
- If you are seeking promotion in a secondary or tertiary department, the request should be made at the same time so you don’t have to prepare another packet.

The Office of Faculty Affairs
Jeannette M. Shorey II, MD, Associate Dean of CME and Faculty Affairs
Preparing the Packet for Promotion and Tenure
A Brief Review

- The P&T Committee
  - Who are they?
  - How are they chosen?
  - When do they meet?
  - How do they make decisions?
  - What happens next?
A Day to Remember!

October 3, 2005
4:00 P. M.
Connie Albert
4D40
Numbers to Remember

- 18 copies of the packet
- 4 copies with reprints (when required)
- 5 reprints (BS, CS, Associate Professor)
- 10 reprints (BS, CS, Professor)
- ? Reprints (CE for Associate or Professor)
Top 5 Problems

- Lack of documentation
- Activities don’t reflect time reported on cover sheet
- No, or inadequate, evaluations of teaching
- Outside letters inadequate, inappropriate
- Wrong track
Outside Letters

- Associate Professor
  - “…at least two letters of recommendation obtained by the Chairman from recognized national authorities in a candidate’s special field of interest not involved in prior training or employment. Other letters of recommendation are encouraged.”
Outside Letters

Professor

"At least three letters of reference must be obtained by the Chairman and submitted to the Dean of the College of Medicine prior to the decision to promote the faculty member to this senior rank. Letters for basic and clinical scientists should come from outside the institution and from recognized authorities in the candidates special field of interest not involved in prior training or employment."
Nuts and Bolts

- Use the Promotion and Tenure Cover Page as a guide for table of contents
- Number the pages
- Be sure the CV is current
- Use tabs for sections
- Loose leaf or bound
- Double space, 12 point
Faculty Affairs - Academic Diary

ACADEMIC ACCOMPLISHMENTS
A YEARLY RECORD

Year 1    Year 2

- TEACHING

- Medical Students
  - Clinical correlations - hours, evaluations - M
  - Clerkship lectures - hours, evaluations - M
  - Preceptorships - hours, evaluations - M
  - Clinical one on one - hours - M
  - Student Advisees - Y
  - Teaching materials developed - list and describe - Y
  - Examination questions or cases written - Y
  - OSCE training and participation - Y

- Graduate Students
  - Major Advisor - number, list - Y
  - Thesis committee member - number, list - Y
  - Qualifying examination committee member - Y
  - Graduate courses - hours, evaluations - M
  - Graduate seminar - hours, evaluations - M
  - Teaching materials developed - list and describe - Y

- Residents
  - Formal lectures - hours, evaluations - M
  - Conferences - hours, evaluations - M
  - Teaching rounds - hours, evaluations - M
  - Clinical one on one - hours - M
  - Teaching materials developed - list and describe - Y

- Fellows
  - Formal lectures - hours, evaluations - M
  - Conferences - hours, evaluations - M
  - Teaching rounds - hours, evaluations - M
  - Clinical one on one - hours - M
  - Teaching materials developed - list and describe - Y

- Continuing Education
  - Formal courses - hours, evaluations - M
  - Grand Rounds - hours, evaluations - M
  - Teaching materials developed - list and describe - Y
Activities (courses, seminars, etc) undertaken to improve teaching - list - M
Community presentations - list, evaluations - M
Professional presentations - list, evaluations - M
Honors or awards - list - Y

- RESEARCH

Grants applied for - list, amount - Y
Grants received - list, amount, term - Y
Publications
Papers

- Peer reviewed - list - M
  On each paper define your role, % effort

- Non peer reviewed - list - M
  On each paper define your role, % effort

- Book chapters - list - M
  On each chapter define your role, % effort

- Abstracts - list - M

Citations - list number of citations of your publications by publication/year - Y
Presentations at meetings

- Program presentation - list - M
- Poster - list - M

Activities (courses, seminars, etc) undertaken to improve research - list - Y
Honors and Awards - list - Y

- CLINICAL

Clinical hours - per wk & total - M
Surgeries, special procedures, etc. - totals - M
Billing and collection - totals - Y
Protocols developed - list - Y
Activities (courses, seminars, etc) undertaken to improve clinical skills - list - Y
Awards and Honors - list - Y

- ADMINISTRATION

Chairman or Dean - time spent - M
Division Chief - time spent - M
Clinic Director - time spent - M
Residency Director - time spent - M
Clerkship Director - time spent - M
Graduate Program Director - time spent - M
Activities (courses, seminars, etc) undertaken to improve administrative abilities - list - M
Committees - Y
PROFESSIONAL RECOGNITION

Journals
- Editorial Boards - list - Y
- Ad Hoc reviewer - list - Y

Office in professional society - list, term - Y
NIH Study Section - list - Y
Invited lectures, professorships - list - Y

MISCELLANEOUS

Radio or TV Shows - list - M
Community Service - list - M
RESIGNATIONS OF EMPLOYMENT AT THE UNIVERSITY OF ARKANSAS

A faculty or staff member has a duty to give early notice of his or her resignation, including the effective date* of the resignation. Notice shall be given in writing to the administrative head of the department to which the individual is assigned. A copy of the letter of resignation, together with the recommendation of the administrative head of the department, shall be forwarded immediately to the dean/director for acceptance or rejection. The dean/director shall give written notice of acceptance or rejection to the employee within five working days of receipt of the letter of resignation. When the written acceptance of the resignation is forwarded by the dean/director to the individual submitting his/her resignation, the resignation becomes final and cannot thereafter be withdrawn.

A copy of the letter of resignation and the acceptance shall be forwarded to the Chancellor of the campus.

*The effective date of resignation shall not be later than the ending date of a current or extended offer of employment to the employee submitting his/her resignation.

March 9, 1984 (Revised)
September 17, 1982
BOARD POLICY

RETIREMENT AGE

Effective January 1, 1987, there is no mandatory retirement age for University employees except tenured faculty.

Until January 1, 1994, tenured faculty are retired at the end of the fiscal year during which the employee shall have attained his or her seventieth (70th) birthday.

August 4, 1992 (Corrected)
June 12, 1992 (Revised)
January 23, 1987 (Revised)
September 20, 1985 (Revised)
May 8, 1981 (Revised)
February 2, 1979 (Revised)
November 3, 1978 (Revised)
February 23, 1976 (Revised)
RETRENCHMENT

Retrenchment is a reduction in programs and/or services which results in the termination of employment only because of (1) a bona fide financial exigency or (2) formal academic planning including Board approved changes in institutional missions, substantial program changes (pursuant to Board Policy 620.1), or major reallocations of resources for academic or support services. In the implementation of retrenchment, fair and humane treatment of faculty, staff, and students is of great concern. Serious efforts shall be made to relocate affected faculty and staff in other parts of the program area or in a different program area of the same campus or division. Similarly, currently enrolled students will be permitted, through special arrangements, to complete a program of studies begun before retrenchment was implemented.

Financial Exigency Retrenchment. A bona fide financial exigency will be certified when a unit of the University of Arkansas is threatened by an imminent monetary crisis which is of such gravity as to make imperative the termination of personnel. A certification of financial exigency shall involve the following steps:

1. The head of a unit\(^1\) proposes a situation of financial exigency documented with budget summaries and projections.

2. Academic administrative personnel and a unit-wide governance standing committee which is representative of unit constituencies shall separately evaluate the documentation and within ten (10) calendar days recommend to the unit head whether they concur with the determination of the bona fide exigency. The governance body shall be informed of the recommendation made by its standing committee.

3. The unit head shall evaluate the recommendations made by the academic administrative personnel and by the committee and shall forward them, along with his/her final recommendation, to the President, who will report the results of the campus deliberation, along with his/her own recommendations, to the Board of Trustees for action.

4. The Board of Trustees shall either certify a bona fide financial exigency and the unit head shall initiate the retrenchment process, or declare the situation to be a financial stringency and the unit head shall ameliorate the situation through budget reductions which shall not involve the immediate termination of personnel.

If the Board of Trustees certifies a bona fide financial exigency, the unit shall initiate retrenchment. The unit head shall consult with appropriate administrators and the standing committee of the governance body before determining that major sub-unit(s) are to be retrenched and the financial level of retrenchment. In determining major sub-units to be retrenched, the following criteria must be

\(^{1}\)Hereafter the Chancellor, Vice President for Agriculture, or director of a unit which reports directly to the President will be referred to as a head of a unit.
considered: (1) centrality of the sub-unit to the mission of the institution, (2) quality of the sub-unit, and (3) cost of the sub-unit, including the relative degree of economic self-sufficiency. In making this determination they shall examine nonacademic areas and programs for possible retrenchment as well as academic programs.

Once the extent of necessary retrenchment has been ascertained, each affected academic dean or administrative officer of nonacademic areas shall be responsible for recommending programs to be retrenched and the number of personnel affected in accordance with criteria and procedures established by the appropriate campus governance body. In recommending programs to be retrenched, the criteria, listed above, must be considered. Alternatives to termination of personnel shall be considered such as early retirement, transfer, voluntary salary reduction, leave-of-absence without pay, as well as normal attrition of personnel, and reductions or postponements in benefits. Within a given department, any faculty member with tenure must be retained over a person who does not have tenure.

The college dean or other administrative officer shall report his/her recommendations to the unit head through appropriate administrative channels. The unit head shall notify the employee(s) who are to be terminated. A person who has been terminated may, in writing, appeal the decision within ten (10) calendar days of the receipt of a certified letter of notification of termination. The appeal shall be based on whether there was material deviation from the established campuswide guidelines for termination because of retrenchment and shall be filed with the unit head and heard by a committee designated by the campus governance body. The committee shall make a report and recommendations within five working days to the unit head who shall make the final decision and notify the appellant immediately.

Classified employees retrenched because of financial exigency will be terminated in accord with Board Policy 405.4 and in no case will termination be effected without 30 days notice. Non-classified employees retrenched because of financial exigency cannot be assured that notice of the duration specified in Board Policy 405.1 will precede termination. Non-classified employees retrenched because of financial exigency shall be given notice at least 60 days in advance of termination.

**Academic Planning Retrenchment:** Academic Planning Retrenchment occurs when faculty, tenured or untenured, are to be terminated as a result of established planning activities. The three reasons for this retrenchment are Board approved changes in institutional mission, substantial program changes and major reallocations of resources for academic or support services. Academic Planning Retrenchment shall involve the following steps:

1. The head of a unit shall propose a retrenchment and justify the proposal with appropriate documentation.

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2The dean of a college or school or the head of a major academic sub-unit.

3See footnote 2.
2. The proposal shall be reviewed and recommendations made by the appropriate academic and other administrators and by the appropriate governance body or bodies. In all cases involving academic programs, the review shall be made pursuant to Board Policy 620.1.

3. The unit head shall evaluate the recommendations and shall forward them, along with his/her final recommendations, to the President, who will report the results of the campus deliberation, along with his/her own recommendations to the Board of Trustees.

If the Board of Trustees declares an Academic Planning Retrenchment, the unit head shall work with the appropriate administrators to determine the needed level of retrenchment and the personnel affected. Within a given academic program, any faculty member with tenure must be retained over a person who does not have tenure.

Faculty members, tenured and non-tenured, who are terminated under Academic Planning Retrenchment shall be given notice specified in Board of Trustees Policy 405.1, Section IV.B. Classified personnel and staff who are terminated under Academic Planning Retrenchment shall be governed by Board of Trustees Policy 405.4, Section 3. Any appeal made as a result of Academic Planning Retrenchment shall be in accord with the existing appellate structure.

All retrenchment recommendations, financial and academic, must be approved by the Board of Trustees.

The foregoing policy shall be utilized only in those instances in which the Board of Trustees has specifically determined that the policy and procedures therein are applicable. It is recognized that the President, Chancellors and the Vice President for Agriculture on occasion may be required to terminate staff or faculty members and other academic employees in positions for which tenure may not be awarded under the provisions of Board Policy 405.4 to implement functional changes, for budgetary reasons or other reallocation of institutional resources. The President, Chancellors and the Vice President for Agriculture shall continue to be authorized to effect terminations of such employees for the foregoing reasons on such terms and under such procedures as they might deem fair, reasonable and appropriate, consistent with the required notification provisions of Board Policy 405.4, and this Board Policy 405.5 shall not be applicable to such terminations.

November 12, 1993 (Revised)
September 14, 1984 (Revised)
February 18, 1983
UNIVERSITY OF ARKANSAS RETIREMENT PROGRAM

Effective July 1, 2002, the University of Arkansas Retirement Program for full-time University employees is revised according to the attached resolution.

RESOLUTION

1. Establishment of Plan. This Retirement Resolution sets forth the provisions of the University of Arkansas Retirement Plan ("Retirement Plan") established by the Board of Trustees of the University of Arkansas (the "University"), as of April 21, 1923, as amended and restated in its entirety effective July 1, 2002. Contributions under this Retirement Plan shall be made pursuant to a 403(b) plan and 457(b) plan to funding sponsors approved under Section 5.

2. Eligibility.

A. Subject to the conditions stated in Section 3 all categories of full-time employees, except for employees of Community Colleges which are not participating in this plan, are eligible to participate in this Retirement Plan; provided, however, that students whose employment is incidental to their educational program at the University are not eligible. For purposes of this Retirement Plan, "full-time employee" shall mean an employee who is on one-half time or greater appointment. Employees of Community Colleges not participating in this plan shall be covered under the retirement plan provided under the terms of the prospective agreement merger.

B. The University is authorized to make Contributions only to this Retirement Plan, the Arkansas Public Employee Retirement System (APERS), and to the Arkansas Teachers Retirement System (ATRS) if a new employee has certain prior participation in the ATRS (as described in D below). The University shall also contribute to Social Security unless the employee is exempt. All newly eligible employees of the University shall be participants in this Retirement Plan unless the employee elects not to participate in this plan. Such election shall be made within 31 days from the date the employee begins employment, and the election shall be irrevocable. If an employee elects not to participate in this Retirement Plan, that employee shall be a member of APERS, effective on date of hire, in accordance with Ark. Code Ann. §24-7-1003. By accepting employment with the University, the employee consents and agrees to complete all necessary documents for enrollment in this Retirement Plan, APERS, or ATRS.

C. Each eligible employee who has become a participant prior to July 1, 2002, under the University's Retirement Plan, APERS, or ATRS under the Board policies then in effect, shall continue to participate in such plan, and the election made under such Board policies shall be irrevocable.

D. Notwithstanding anything in this resolution to the contrary, all eligible employees of the University who have been a member of the Arkansas Teacher Retirement System for a minimum of five (5) years, may, in lieu of the election required in paragraph 2(B) herein above, elect to participate in the Arkansas Teacher Retirement System subject to its applicable laws,
rules, and regulations and the University is authorized to make contributions to that system for such employees.

3. **Employee Participation.** All eligible employees will begin participation in this Retirement Plan on the first day of the month coinciding with or next following benefits enrollment at the University. In the event a participant has separated from service and is rehired, the participant will again participate on the first day of the month coinciding with or next following benefits enrollment with the University, notwithstanding that the participant may have begun receiving distributions under this Retirement Plan which continue after date of rehire.

4. **Plan Contributions.** Employer contributions for eligible employees will begin to accrue as of date of employment. The University will make a basic Plan Contribution of five percent of regular salary for all eligible employees. Eligible employees may make voluntary Plan Contributions in any amount as agreed by the participant and the University, subject to the contribution limitations of the Internal Revenue Code. Employees who make voluntary Plan Contributions in excess of five percent of regular salary will be eligible for a matching University Plan Contribution on the amount in excess of five percent up to a total University Plan Contribution, both basic and matching, of ten percent of regular salary.

Plan Contributions by a participant will be made first to a 403(b) program and then may be made to a 457(b) program, if elected by the participant, and shall be made on a before-tax basis or after-tax basis, as elected by the participant in accordance with 403(b) or 457(b), as applicable, of the Code. University contributions will be made to the 403(b) contract or account.

Plan Contributions shall be forwarded to the applicable funding sponsor selected by the participant and may be allocated by the participant between such funding sponsors in any proportion which the participant chooses.

5. **Funding Sponsors.**

A. **Alternative Funding Sponsors.** The Plan has been funded through TIAA and/or CREF annuity contracts since April 21, 1923. A participant may select either TIAA-CREF or Fidelity Investments as a funding sponsor. Contributions to Fidelity Investments shall be applied either to individual annuities issued under a Metropolitan Life Guaranteed Account and/or one or more mutual fund accounts managed by Fidelity Investments. Contributions to TIAA-CREF shall be applied either to individual annuities issued by Teachers Insurance and Annuity Association (TIAA) and/or College Retirement Equities Fund (CREF). No other alternative funding sponsors are authorized.

B. **Transfers between authorized funding sponsors.** A participant may transfer all or any portion of his/her account under a funding sponsor to the other authorized funding sponsor, subject to any limitations imposed by TIAA or the Metropolitan Life Guaranteed Account.
6. **Vesting.**

   A. All benefits attributable to Plan Contributions made by both the University and the participant are immediately vested in the participant for:

   1. All faculty members and all other non-classified employees.

   2. All classified employees whose initial employment occurred prior to July 1, 1985, and who made any Plan Contributions prior to that date.

   B. All other employees other than those described in A.1 or A.2 above, vesting of benefits attributable to Plan Contributions made by the University shall occur on the earlier of:

   1. Completion of three years of service,

   2. Attainment of age 65, or

   3. The participant's having made Plan Contributions of at least five percent of regular salary for six consecutive months.

7. **Application Form.** The participant shall complete an application form in order for the annuity contract(s) or custodial accounts to be issued or established. Each annuity contract issued or custodial account established under the Retirement Plan is for the purpose of providing a retirement or death benefit.

8. **Leave of Absence.** During a leave of absence, the University will continue its Plan Contributions for a participant, at the rate specified, on the basis of salary then being paid by the University. During a leave of absence without pay, no Plan Contributions will be made except as required by federal law.

9. **Distributions.**

   A. Upon separation from service with the University, a participant may receive a distribution of his/her vested balance under CREF or any Fidelity Investments mutual fund. Such distribution may be in a lump sum or pursuant to a distribution option under Section 10.

   B. Upon separation from service with the University, a participant may receive a distribution of his/her vested balance under TIAA or the Metropolitan Life Guaranteed Account under any distribution form allowed by such contracts.

   C. In the event a Participant in this Retirement Plan, who has not achieved vesting in accordance with the provisions of Section 6, terminates employment for reasons other than death or disability, the portion of the account attributable to Plan Contributions made by the
University will be paid to the University by the respective funding sponsors. The portion of the account attributable to Plan Contributions made by the Participant shall remain in the annuity contract(s) or custodial accounts to provide retirement and/or death benefits for the Participant or, at the option of the Participant, shall be distributed in accordance with Section 9(A) or (B).

D. Except for as otherwise provided in the participant’s 403(b) contract with TIAA-CREF, no distribution shall be allowed to any participant under the Retirement Plan prior to separation from service with the University, subject to such provisions in Paragraph 3 above; provided, however, that in the event a participant has entered into an agreement under the University’s early retirement program, such participant may, if over the age of 59½, begin receiving distributions from his or her 403(b) accumulation even though the participant has not separated from service with the University. Further, any participant, if over the age of 59½, may begin receiving distributions of the employee portion of his or her 403(b) retirement accumulation even though the participant has not separated from service with the University.

10. Retirement Benefits. Upon retirement at any age, a vested participant shall be entitled under the terms of his or her annuity contracts/custodial accounts to receive a monthly or other periodic income under any one of the options set forth in such contracts/accounts. Participants initiate procedures for receipt of retirement income benefits by writing directly to the applicable funding sponsor.

11. Death Benefits. In the event a participant dies while employed, all accumulations are 100% vested. If a participant dies prior to commencement of retirement benefit payments, the vested amount of the participant's account is then payable to the beneficiary or beneficiaries named by the participant, in a single sum or under any one of the income options offered by the funding sponsor.

12. Application for Benefits. Benefits provided by annuities/custodial accounts to which Plan Contributions have been applied will be payable by the applicable funding sponsor upon receipt by the funding sponsor of a satisfactorily completed application for benefits and supporting documents. The necessary forms will be provided to the participant or beneficiary by the funding sponsor.

13. Spendthrift Clause. No participant in the Retirement Plan shall have any right to assign, pledge, encumber, or commute his/her interest in any benefits under this Retirement Plan, either voluntarily or involuntarily, and such benefits shall not in any way be subject to any legal process or levy of execution upon, or attachment or garnishment proceedings against, the same for the payment of any claim against any such person.

14. Amendment. While it is expected that this retirement plan will continue indefinitely, the Board of Trustees reserves the right to modify or discontinue the Retirement Plan at any time. The Board may also delegate any of its powers and duties with respect to the plan or amendments, to one
or more officers or other employees of the University. Any such delegation shall be set forth in writing.

Any discontinuance or modification of the plan cannot adversely affect the benefits accrued by participants prior to the date of discontinuance or modification.

15. Administration. The President of the University or his/her delegate may adopt rules and regulations for interpreting this Retirement Plan and for administering its provisions (including rules and regulations concerning funding sponsors) in a manner consistent with this Board Policy. This shall include the authority to determine terms and conditions (including designation of funding sponsors) under which employees of technical institutes merging into a campus of the University shall participate in this Plan.

\[1\]Regular salary for faculty shall mean contract salary; for all other employees, regular salary shall mean basic annual earnings exclusive of overtime pay; and in all cases, regular salary shall be determined without reduction for any Section 125 Cafeteria Plan benefits or elective contributions to the 403(b) plan, a 457 Plan or elective contributions under a qualified transportation program under IRC § 132(f)(4). For Plan Years beginning after December 31, 2001, the annual salary of each employee taken into account under the plan shall not exceed $200,000, as adjusted for cost-of-living increases in accordance with Section 401(a)(17)(B). Annual compensation means compensation for the calendar year.

June 6, 2003 (Revised)
April 5, 2002 (Revised)
January 26, 2001 (Revised)
November 8, 1996 (Revised)
June 7, 1996 (Revised)
April 22, 1994 (Revised)
January 21, 1994 (Revised)
November 12, 1993 (Revised)
November 20, 1992 (Revised)
August 10, 1992 (Corrected)
May 1, 1992 (Revised)
September 21, 1990 (Amendment)
May 4, 1990 (Revised)
(For Revisions Prior to 1990 Refer to Previous Board Policies File)
Faculty Resources

UAMS Campus Policies in the Administrative Guide

2. Selected Policies Governing Faculty Service and Responsibilities

- Academic Visit Status for UAMS Campus (with Appointment Form) (Admin Policy 12.0.00)
- Appointment of Academic Personnel (Admin Memorandum 410.1)
- Distribution of Royalties From Patents, Copyrights and Licenses (Admin Policy 12.1.05)
- Drug Testing (Admin Policy 3.1.04)
- Early Retirement of Tenured Faculty (Admin Memorandum 430.2)
- Employee Assistance Program (Admin Policy 3.1.09)
- Employee Basic Code of Conduct (Admin Policy 4.4.01)
- Ethical Conduct/Gift Policy (Admin Policy 4.4.09)
- Ethical Standards in Research (Admin Policy 12.1.04)
- Extra Compensation (Admin Memorandum 440.2)
- Honorariums (Admin Guide 5.1.06)
- Implementation of Board Policy on Political Activity (Admin Memorandum 455.1)
- Lump Sum Terminal Pay (Admin Memorandum 440.4)
- Media Relations (UAMS Medical Center) (Admin Policy 14.01.01)
- Outside Employment for Faculty and Staff members for Compensation (Admin Memorandum 440.7)
- Policy on Conflict of Commitment and Conflict of Interest
- Policy Governing Service of Volunteer Faculty (Admin Memorandum 410.3)
- Recommendation for Tenure (Admin Memorandum 420.1)
- Review of Promotion and Tenure Criteria (Admin Memorandum 421.2)
- Services for "Non-Employees" (Academic Visitors) (Admin Policy 4.5.28)
- UAMS Institutional Policy on the Use of Copyrighted Materials (Admin Memorandum 12.0.2)
- Voluntary Early Retirement for Non-Tenured Faculty and Staff (Admin Policy 440.7)
The complete UAMS Administrative Guide may be found at http://uams.edu/AdminGuide/index.html

Back

10/13/2005
POLICY

In order to promote campus scholarly activities, there are many instances in which persons without a continuing formal status as student, faculty, or employee may engage in activities on campus and need to use campus facilities.

Persons who hold academic teaching appointments in an established college or university and who are appointed to a visiting teaching position at UAMS may be given a visiting appointment at UAMS at the same or equivalent rank they hold at their home institutions. Visiting faculty, fellows, and students who do not hold regular academic rank at another institution may be appointed as visiting lecturers or fellows.

PROCEDURES

A. A Visiting Staff Member Appointment Form is required (page 3 of this policy). The appointment form will be approved by the appropriate Dean or Cabinet level official and forwarded for approval to Vice Chancellor for Academic Affairs. Complete forms should indicate length of stay, scope of responsibilities, requested privileges and/or fringe benefits. The Vice Chancellor for Academic Affairs will route approval to appropriate departments for access and application of requested privileges.

1. All visiting staff with stays over 10 working days must be issued campus ID badges.

2. If requested and approved, visiting staff with ID badges may have access to campus facilities, such as the Library, Laboratories, Computing Services, Human Resources or Immigration, key or key card issuance, etc.

3. The host department is expected to assume financial backup responsibility for any privileges extended (dormitory damage, telephone bills, overdue or missing books, parking tickets, etc.).

B. Appropriate titles may include:

1. **Standard faculty ranks, modified by the descriptor "Visiting":**

   These titles may be used in cases where there is some compensation from some source, but do not automatically carry any eligibility to vote on faculty matters (unless otherwise specified in the College by-laws). Appointment request package must include FAF (Faculty Appointment Form).

2. **Miscellaneous special titles, modified by the descriptor "Visiting" or "Guest":** (Visiting Scholar, Visiting Researcher, Visiting Research Fellow, College of Pharmacy Guest, etc.). Access to privileges should be requested on appointment form. Privileges will be on an ad hoc basis as arranged by the host unit with the service provider.

3. **Visiting Students or Clerks:** Regulations will vary by College; the LCME has published
guidelines for visiting medical students, and these regulations will be considered to be in effect for such students - they may include requirements for registration, payment of some fees, proof of health insurance, issuance of grades, etc.

Visiting student status must be approved by the Dean of the appropriate college prior to arrival on campus. In the special case of graduate students, both College and Graduate School Deans must approve prior to the visitor arriving on campus.

Special Considerations for Visiting Housestaff:

A housestaff member (also termed intern, resident or fellow) is an individual selected through one of the matching programs or accepted selection processes for the residency/fellowship. The individual must intend to complete the entire training program. Elective or short-term rotations by trainees from institutions outside UAMS are discouraged. All requests for elective or short-term rotations by trainees from other institutions must be made by the departmental chair and approved by the GME Committee. Requests to the GME Committee must include the following information about each trainee:

1. Institution of current program
2. Length of rotation
3. Credentials including medical school graduation and/or ECFMG certification, or full and unrestricted license to practice in the US
4. Financial source of stipend, benefits
5. Person who assumes malpractice responsibility at UAMS

UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES
VISITING STAFF MEMBER APPOINTMENT FORM

Name of Appointee: _____________________________________________

SSN or INS Number:______________________________

College: __________________________________ Date: __________________________

Department: _______________________________ Requesting Chair: _______________________

Department Number: ________________________ Slot: __________________________

RequestedTitle:________________________________________________________________________

Requested Appointment Period-Starting Date: _______________Ending Date: ___________________

Requested Percent Time:________________________________________

Source of Compensation:_________________________________________________________

Reason/Justification of Appointment:_______________________________________________

________________________________________________________________________

http://uams.edu/AdminGuide/Win12000.html
Requested Privileges/Benefits (i.e. computer access, library, hospital, courtesy privileges, malpractice coverage):

__________________________________________________________

Home Account Number for Financial Backup: _______________________

Approvals:

Department Chair: ___________________________ Date: _____________

Dean: ________________________________ Date: ______________

Vice chancellor for Academic Affairs: _________________ Date: ______________

ALL SIGNATURES MUST BE OBTAINED AND CURRENT CURRICULUM VITAE MUST BE ATTACHED OR FORM WILL NOT BE ACCEPTED

Attach other documents as required (network security acknowledgment, Asst. Dean for GME authorization, other).
APPOINTMENT OF ACADEMIC PERSONNEL

1. Vitae must be attached to appointment forms for academic personnel who are being recommended for rank of Instructor or higher position. Complete campus files, including letters of recommendation, must be available for those being recommended for Department Chairperson (or Head), Assistant or Associate Dean, Dean, and Vice Chancellor, and must indicate that affirmative action guidelines have been followed.

2. The Chancellor will interview applicants and approve all appointments for Dean and Vice Chancellor.

3. Questions of rank and salary should be discussed with the Vice President for Academic Affairs prior to submitting the appointment.

4. No appointment is official until a signature has been affixed to the personnel action form in the President's Office.

5. Appointment with tenure will have prior Presidential approval.

January 9, 1984 (Revised)
October 30, 1978 (Revised)
December 5, 1975 (Revised)
November 17, 1975
The purpose of this policy is to notify colleges and researchers within the University of Arkansas for Medical Sciences (UAMS) of the procedures that are followed when allocating the costs and the distribution of income resulting from a successful patent, copyright or license.

It is the policy of the University of Arkansas to acquire and retain legal title to all inventions created by any person or persons to whom this policy is applicable. This policy is established in furtherance of the commitment of the University to the widest possible distribution of the benefits of University Research, the protection of Inventions resulting from such research, and the development of Inventions for the public good.

This policy shall apply to all persons employed, compensated, or appointed by the University and to anyone using facilities owned, operated, or controlled by the University. It shall also apply to all Inventions financed, in whole or in part, from funds under the control of UAMS.

PROCEDURE

1. All persons to whom this policy is applicable shall petition the UAMS Patent and Copyright Committee of their intent to seek a patent or copyright. The Patent and Copyright Committee will decide whether to seek the patent, copyright or license; release the petitioner; or take no action.

2. The UAMS Patent and Copyright Committee will notify the General Counsel of the University of Arkansas System if they wish to seek a patent or copyright. The General Counsel’s Office will obtain Counsel on behalf on the University and the petitioner. The legal costs related to the application of the patent, copyright, or license are charged back to UAMS.

3. Once a patent, copyright, or license is obtained, sale of the patent, copyright, or license is negotiated by the UAMS Office of Research Administration and the General Counsel of the University of Arkansas System together with the appropriate college or the researcher.

4. When a contract is approved and payment is received by the Controller’s Office it will be deposited into the Patent, Copyright and License Control Account. The Controller’s office will make distribution within 30 days of deposit of the royalty payment in the UAMS Treasurer’s Office. The Controller’s Office will reduce the payment amount by the actual costs for patenting, licensing, and the protection of patent rights and copyrights. If the cost of obtaining the patent, copyright, or license exceed 20% of the initial payment, only 20% will be charged against the initial payment. The balance of the costs will be charged against succeeding payments, with a maximum of 20% of any single payment being charged, until all costs are covered. The net distribution will be as follows:

For net royalty proceeds for income up to $200,000

For Income over $200,000

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Distribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>50% to the Inventor(s)</td>
<td>35% to Inventor(s)</td>
</tr>
<tr>
<td>5% to the U of A System</td>
<td>5% to U of A System</td>
</tr>
<tr>
<td>31.5% to the Appropriate College</td>
<td>42% to Appropriate College</td>
</tr>
<tr>
<td>13.5% to the Chancellor &amp; Processing Reserve</td>
<td>18% to Chancellor &amp; Processing Reserve</td>
</tr>
</tbody>
</table>

For example, if a patent is sold for $100,000, and legal costs were $10,000, the net proceeds of $90,000 will be distributed as follow:

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross Receipt</td>
<td>$100,000</td>
</tr>
<tr>
<td>Less: Direct Costs</td>
<td>$10,000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Available for Distribution</td>
<td>$90,000</td>
</tr>
<tr>
<td>Distribute to Inventor (50%)</td>
<td>$45,000</td>
</tr>
</tbody>
</table>
If a patent sold for $300,000, and legal costs were $10,000 the net proceeds of $290,000 will be distributed as follows:

<table>
<thead>
<tr>
<th>Distribute to UA System (5%)</th>
<th>4,500</th>
</tr>
</thead>
<tbody>
<tr>
<td>Distribute to Appropriate College (31.5%)</td>
<td>28,350</td>
</tr>
<tr>
<td>Distribute to Chancellor (3.5%)</td>
<td>12,150</td>
</tr>
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Gross Receipt $300,000
Less: Direct Costs 10,000
Available for Distribution 290,000

First $200,000 Additional $90,000

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5. Contact the Office of Research Administration for assistance and additional information.

1. UofA Board Policy 210.1 - Patent and Copyright Policy
To promote the health, safety and productivity of our employees, it is the policy of UAMS to provide a drug-free workplace. To support our goal of a drug-free environment, the UAMS drug testing program will consist of (1) pre-employment drug testing, (2) for cause drug testing, and (3) random drug testing. All procedures outlined herein should be deemed consistent with policies 4.4.05 (Drug Free Workplace), 4.4.06 (Substance Abuse Policy), and 4.5.18 (Post Employment Medical Screening) in the UAMS Administrative Guide.

DEFINITIONS

I. **Pre-employment Drug Testing** - Once an applicant in a testable position has been selected for employment, he/she will be required to submit to a drug test. Employment will be finalized only upon completion of a negative drug test. Refusal to submit to the drug test will be interpreted as a withdrawal of the application.

II. **For Cause Drug Testing** - An employee in a testable position whose behavior is consistent with substance abuse can be required by their immediate supervisor to submit to a drug screen. Behavior indicating substance abuse may include:

A. Observed impairment of job performance.

B. Abnormal conduct or erratic behavior.

C. A serious workplace accident or number of minor workplace accidents.

D. Evidence of drug tampering in the employee’s workplace.

E. Arrest or conviction on an alcohol- or drug-related offense.

Suspicious behavior should be documented on the form appended to this policy (Attachment I). This form is to be retained in the departmental personnel file. Employees meeting any of the above criteria, or other reasonable criteria utilized by the supervisor, may be required to submit to a drug test. Refusal or failure to submit to a timely drug test is sufficient cause for termination of employment.

III. **Random Drug Screening**

At a specified interval, employees in testable positions will be selected for drug screening using a random sampling methodology. Employees will not receive notification of their selection and will be required to submit a sample at the specified location and time.

IV. **Testable Positions**

A position at UAMS that has been designated for drug testing. Testable positions include all direct patient care positions, all safety-sensitive positions and other special needs positions. An illustrative list of Testable positions are identified in Attachment II to this policy.

V. **Medical Review Officers**

The medical review officer is a physician responsible for receiving and reviewing drug test results. The medical review officer is designated by the Chancellor.
PRE-EMPLOYMENT DRUG TESTING PROTOCOL

A. Drug testing shall be completed prior to starting work. Managers who allow employees to begin work prior to receiving at least verbal confirmation from Human Resources of a negative drug test will be subject to disciplinary action.

B. At the time an offer of employment is extended, the potential employee will be given instructions on submitting a urine sample for drug testing. The sample will be tested qualitatively for at least the following substances: Marijuana, Cocaine, Opiates, Amphetamines, Phencyclidine (PCP), Barbiturates, or derivatives thereof. The sample may be tested for other drugs as necessary.

C. Within 24 hours of the submission of a urine sample, negative results will be communicated to Human Resources. Within a subsequent 24-hour period (excluding weekends), Human Resources will notify the department of negative results by phone and will follow with written notification by mail.

D. If an initial screen produces a positive result, a confirmatory test on the same sample will be conducted. If the confirmatory test is also positive, the result will be turned over to the MRO.

E. The Medical Review Officer will schedule an appointment with the applicant to discuss the results. The test results will be interpreted by the Medical Review Officer and reported to Human Resources. Upon the advice of the Medical Review Officer, the department will notify the applicant that the offer of employment is being withdrawn and will encourage the applicant to seek treatment.

II. FOR CAUSE DRUG TESTING PROTOCOL

A. If an employee’s behavior causes reasonable suspicion of alcohol or drug abuse, a supervisor will request to a department head that a drug screen be performed. The department head or acting department head has authority to direct a for cause drug test. Should the Supervisor or department head have questions whether to direct a for cause drug test, a call may be made to the Employee Assistance Program (EAP) at 686-2588. A staff member will be made available for consultation and assistance in making a decision to test for cause.

B. The employee to be screened shall be relieved of his/her duties and will be given a specific time and date (less than two hours) that he/she is to report to the testing facility. Failure to report at the specified time, without pre-approval of the supervisor, is sufficient cause for immediate termination. In the event that the employee is obviously impaired, the consulting staff member will make arrangements with UAMS Police to provide transportation to the testing facility.

C. The submitted sample (blood and/or urine, as appropriate) will be screened for the following substances: Marijuana, Cocaine, Opiates, Amphetamines, Phencyclidine (PCP), Barbiturates, or derivatives thereof and other drugs deemed necessary. If an initial screen returns a positive result, a confirmatory test on the same sample will be conducted. If the confirmatory test is also positive, the result will be turned over to the MRO.

D. The Medical Review Officer will schedule an appointment with the employee to discuss with him/her the results and inform the employee’s department head.

E. The department head will determine the action necessary when an employee tests positive for a drug of abuse. Options available to the department head will be up to and including immediate termination. The department head will consider corrective actions that may be initiated by the employee, including consultation and corrective treatment protocols in cooperation with outside professional expertise and/or with the Employee Assistance Program (EAP). The decision of the department head is final.

F. Any employee terminated for cause will be ineligible for rehire for at least six months.

III. RANDOM DRUG TESTING

A. Random screening will include all testable positions.

B. Employees will not receive prior notification of drug test. They will be escorted to the UAMS Laboratory for testing. The employee must immediately report for testing once receiving notification from the OHR representative.

C. Failure to submit the sample as directed is sufficient cause for termination.

D. The Medical Review Officer will schedule an appointment with the employee to discuss with him/her the results and inform the employee’s department head.

E. The department head will determine the action necessary when an employee tests positive for a drug of abuse. Options available to the department head will be up to and including immediate termination. The department head will consider corrective actions that may be initiated by the employee, including consultation and corrective treatment protocols in cooperation with outside professional expertise and/or with the Employee Assistance Program (EAP). The decision of the department head is final.

F. Any employee terminated for cause will be ineligible for rehire for at least six months.
F. Any employee terminated for cause will be ineligible for rehire for at least six months.

IV. TESTING PROCEDURES

A. Employees identified for testing will not receive prior notification.
B. A representative from the Office of Human Resources will accompany all employees to the UAMS laboratory. Once approached, the employee will be escorted promptly to the UAMS Laboratory for testing. Employees must bring their photo identification (ID), e.g., driver’s license, ID badge, etc. Employees must report immediately.
C. Refusal to undergo required drug testing will result in disciplinary or adverse action up to and including removal. Attempts to alter or substitute a specimen will be treated as a refusal to take a drug test.
D. Individuals being tested may provide to the Medical Review Officer information on any prescription medication they are taking which could affect the test results. Such information will be kept confidential.
E. Urine Collection Procedures:
   1. Specimen will be provided in a secure collecting facility.
   2. Donor leaves unnecessary outer garments in secure holding area. Personal items (such as briefcases, handbags and packages) must be left in holding area.
   3. Collector provides donor a wrapped/sealed collection container and specimen bottle.
   4. Donor provides specimen in secured area.
   5. Collector receives specimen and places cap securely on container.
   6. Collector places seal over bottle and dates the seal.
   7. Donor initials security seal after attached to bottle.
   8. Collector initials and dates the seal area of the security bag and the shipping container (if used).
F. All positive results will be reported to the Medical Review Officer.

V. OTHER CONSIDERATIONS

A. Test results will be granted confidentiality in accordance with all federal and state laws and UAMS policy. Tests will be performed off-site and will be paid for by UAMS (unless the tests are performed in accordance with an employee contract that states otherwise). Notification of any other agency or licensing board will be accomplished by the department in accordance with state and federal law.
B. Applicants may be asked to provide information as necessary to interpret drug screen results. Such information will be considered confidential.
C. Attempts to alter or substitute a specimen will be cause for withdrawal of the application for employment or immediate termination, even if the attempt is discovered after the period of employment begins.
D. This policy shall not be construed to address aspects of substance abuse policy and procedure other than pre-employment, for cause, and random drug testing. See UAMS policy 4.4.05 for policies that govern the use, possession, manufacture, purchase, or distribution of controlled substances on campus.

ATTACHMENT I

**Supervisor Documentation Form**

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## 3.1.14 Drug Testing

ATTACHMENT II

TESTABLE POSITIONS – SUBJECT TO CHANGE

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<td>Auto/Diesel Mechanic</td>
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<td>Cook II</td>
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<td>0B35</td>
<td>Biomedical Instrument Engineer</td>
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<td>Custodial Worker I</td>
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[http://uams.edu/AdminGuide/Win03114.html](http://uams.edu/AdminGuide/Win03114.html)
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11/1/2005
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VOLUNTARY EARLY RETIREMENT PROGRAM FOR TENURED FACULTY

I. GENERAL PURPOSE

The voluntary early retirement program ("the Program") of the University of Arkansas ("the University") for tenured faculty is made available to eligible tenured faculty. Under the terms of the Program, the faculty member will receive certain benefits in exchange for his/her immediate retirement and relinquishment of tenure. Participation in the Program is voluntary and is not mandated upon either tenured faculty or the University. Participation in the Program is not an entitlement but may be made available to eligible tenured faculty members when:

1) A savings to the University can be demonstrated, and

2) The terms and circumstances of the retirement would not be detrimental to the University and its programs including, but not limited to, sufficient financial and staffing resources available to the department, campus, and unit from which the individual is retiring.

II. PROCEDURES FOR SUBMITTING EARLY RETIREMENT REQUESTS:

Any tenured faculty member meeting the minimum qualifications listed below may initiate a request for the University to consider the faculty member’s participation in the Program. The request must be submitted in writing by the faculty member to the head of the faculty member’s unit. Each campus will be responsible for developing and informing faculty of a time schedule for submission of early retirement requests. Participation in the Program is subject to approval of the Board of Trustees of the University of Arkansas ("the Board") and shall be evidenced by a written agreement between the individual and the University. Each voluntary early retirement agreement ("the Agreement") must be approved by the Board prior to the effective date of retirement of the faculty member. The Agreement shall be in a standard form, approved by the General Counsel of the University, setting forth its terms.

Within the guidelines listed below, the terms of the Agreement should be discussed between the faculty member and the head of the faculty member’s unit. Each campus may also designate one or more individuals to consult with the faculty member in evaluating the Agreement although the campus representative is not authorized to furnish legal, tax or other professional advice. In developing the Agreement, each faculty member must be apprised of his/her rights under the Age Discrimination in Employment Act and be advised to seek the advice and counsel of attorneys, accountants and others who can provide the faculty member with information to assist in making an informed decision. In all cases, the faculty member should be given at least 45 days to consider his/her participation in the Program unless the faculty member waives this requirement in writing. Waivers shall be in a standard form approved by the General Counsel of the University.
If the faculty member and the head of the unit agree on an early retirement request, in accordance with the Program, an Agreement should be completed and forwarded for approval through administrative channels, together with a letter of recommendation from the appropriate Chancellor or the Vice President for Agriculture, to the President of the University. Each Agreement must be accompanied by:

1) A statement signed by the requesting faculty member, assuring University officials that the faculty member’s participation in the Program is voluntary; and

2) An "early retirement worksheet," in a form substantially corresponding to the form attached to this Universitywide Administrative Memorandum.

III. MINIMUM QUALIFICATIONS

1) The Program is not available to a faculty member who is on leave-without-pay; receiving long-term disability insurance benefits; or receiving worker’s compensation.

2) On the effective date of a participating faculty member’s retirement pursuant to an Agreement, the faculty member shall:

   a) be age 55 or older, and

   b) Have 15 years of continuous service in a tenured or tenure track faculty position with the University of Arkansas.

   "Continuous service in a tenured or tenure track faculty position" means 15 consecutive years of service, subject to provisions herein for leave-without-pay status.

   "Tenured or tenure track faculty position" shall be as defined in Board Policy 405.1. For purposes of the Program, individuals who held a tenured faculty position prior to or contemporaneous with the assumption of administrative duties in connection with the positions of President or other System administrator, Chancellor, Vice Chancellor for Academic Affairs, Dean, or Department Head/Chair and who continue to hold tenure throughout their employment as administrators shall be considered as holding a tenured or tenure track faculty position during such period of administrative service.

   "Years of service" will be calculated in whole year increments. In the case of an individual on twelve-month appointment, fractions of years of service that are six months or less will be rounded down to the next lowest full year of service and fractions of years of service that are greater than six months will
be rounded up to the next highest year of service. In the case of an individual on nine-month appointment, years of service will be calculated with the fall and spring semester each representing half a year.

Time spent in an "off campus duty assignment" will be counted in computing continuous service.

Time spent in a "leave-without-pay" status will not be counted in computing continuous service but faculty members who have no more than three years in a leave-without-pay status are not prevented from participation in the Program as long as they can otherwise show fifteen years of service. For Example: X begins his/her appointment in the fall of 1976 and works continuously until the end of the spring term in 1986. From the beginning of the summer term 1986 until the fall term of 1988, X is in a leave-without-pay status. X returns to active status in the fall of 1988 and works until the end of the spring term of 1993. X has fifteen years of service and can participate in the early retirement program.

"Service . . . with the University of Arkansas" means service at any of the campuses or the System Office of the University of Arkansas.

IV. PROGRAM REQUIREMENTS

Before an Agreement can be approved, a "net savings in personnel costs" to the University must be identified. The cost savings must be realized within seven years of the effective date of the Agreement. A cost savings will be determined for each year of the seven-year period by subtracting the retirement cost and replacement cost from the retention cost. The fact that a cost savings is not shown in one year will not prevent a faculty member from qualifying for the Program if a total cost savings can be realized over the seven-year period. For purposes of this Program:

"Retirement cost" means the cost of all benefits, including future part-time teaching, research or other employment-related costs of the faculty member;

"Replacement cost" means the estimated salary and fringe benefits cost of the individual or individuals who will be employed to fill the position or responsibilities of the retiring faculty member;

"Retention cost" means the last annual salary and fringe benefits cost of the retiring faculty member, including any increases in salary or fringe benefits approved prior to the effective date of an Agreement.

The maximum dollar value of benefits that can be received under an Agreement is the
current annual salary of the retiring faculty member or such lesser amount as is necessary to show a cost savings to the University within seven years. Current annual salary shall be based upon the academic year (for faculty members on nine-month appointment) or fiscal year (for faculty members on twelve-month appointment).

The benefits may take several forms including but not limited to:

- Stipend without requiring work;
- Wages for part-time work (subject to the provisions set out below);
- Contribution to a designated funding sponsor under the University Retirement Plan;
- Reimbursement for major medical and/or life insurance premiums;
- Other arrangements.

Wages for part-time work shall not exceed 5/16 of the faculty member’s last full-time annual salary. If the retiring faculty member plans to return to the University on a part-time basis at any time during the seven years immediately following early retirement, the cost of the part-time employment must be calculated as “retirement cost” for purposes of showing a cost savings to the University.

V. SPECIAL CAMPUS PROGRAM--APPROVAL BY PRESIDENT

The Chancellor of any campus may submit to the President for approval a special voluntary early retirement program applicable only to tenured faculty members on that campus. Such a proposal may provide for benefits or incentives for a limited period of time beyond the benefits set forth in this Program and may also be limited to tenured faculty members within a minimum and maximum age classification. The proposal may also modify the eligibility criteria of the Program and may include an option for relinquishment of tenure under a phased retirement Agreement whereby the faculty member reduces workload over a period of not more than three years. Incentive payments for a phased retirement proposal may include special allowances and/or payment of all or a portion of continued insurance coverages. Any such proposal must be consistent with Board Policy and applicable law, meet the general purposes set forth in the preamble to this Universitywide Administrative Memorandum and must be justified by the Chancellor with such substantiation as the President might direct.

June 1, 1994
VOLUNTARY EARLY RETIREMENT AGREEMENT

This Agreement is entered into by and between ____________________________, a member of the faculty of the University of Arkansas at its ______________ campus, and the Board of Trustees of the University of Arkansas, on this the _____ day of _____________, 19____.

__________________________________________
states:

That he/she has been a member of the faculty of the University of Arkansas since ______________, currently holds the rank of ____________________________ , and is tenured in that position under policies of the Board of Trustees.

That he/she is not on leave-without-pay status, receiving long-term disability insurance benefits, or receiving workers compensation benefits;

That on his/her own initiative, he/she has sought an agreement for early retirement pursuant to Arkansas Code Annotated §24-7-101 and Universitywide Administrative Memorandum 430.2;

That he/she has been apprised of his/her rights under the Age Discrimination in Employment Act as amended;

That he/she has been advised and has had the opportunity to seek the advice and counsel of attorneys, accountants, and others who could aid him/her in making an informed decision regarding the early retirement program;

That he/she has been given at least 45 days to consider his/her participation in the program; and

That he/she voluntarily does hereby resign his/her position as a tenured ______________ effective ______________, recognizing and acknowledging that all rights and obligations as a tenured faculty member will then end.

In consideration for the resignation as a tenured faculty member as described above, the Board of Trustees of the University of Arkansas hereby accepts such voluntary resignation and in consideration thereof agrees to provide the following:

(1)__________________________________________________________________________

(2)__________________________________________________________________________
This agreement shall be binding on the tenured faculty member described above, and on his/her heirs, estate and personal representatives, and on the Board of Trustees and its successors; provided, however, that (1) any agreement to pay for part-time personal services shall terminate for all unearned and unearned amounts on the death or disability to render such services, personally, by the tenured faculty member described, and (2) all other rights and/or obligations to or for the benefit of the tenured faculty member described shall terminate at his/her death except as they may have accrued, as to rights, prior to such death.

All earlier oral or written agreements regarding employment between the Board of Trustees of the University and/or the University of Arkansas and are superseded by this Agreement. This Agreement does not affect or alter the rights, privileges, or options accrued to this date which now has under pension (annuity), insurance, or other plans (if any) in which has participated and to which the University has made contributions, nor any rights, privileges, or options to which emeriti faculty members are entitled by reason of that rank or eligible therein.

Witness:


Faculty Member

Witness:

Board of Trustees of the University of Arkansas

By:
EARLY RETIREMENT WORKSHEET

NAME: ___________________________  BIRTHDATE: __________

POSITION & DEPARTMENT: ___________________________

DATE OF EMPLOYMENT: __________  DATE OF RETIREMENT: __________

YEARS ON APPOINTMENT: __________  AGE AT RETIREMENT: __________

CURRENT APPOINTMENT: ___________________________  SALARY: ___________________________

PERIOD (9 or 12 months) __________  (Current Year): __________

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STATEMENT OF ASSURANCE

By my signature below, I, __________________________, do hereby assure the members of the Board of Trustees of the University of Arkansas that I have voluntarily sought participation in the University of Arkansas' Voluntary Early Retirement Program for Tenured Faculty, that I have been apprised of my rights under the Age Discrimination in Employment Act, and that I have been advised and have had the opportunity to seek the advice and counsel of attorneys, accountants and others who might assist me in making an informed decision concerning the Program.

Faculty Member __________________________ Date __________

Witness __________________________ Date __________
VOLUNTARY EARLY RETIREMENT PROGRAM
WAIVER OF 45 DAY CONSIDERATION

I, __________________________, hereby waive the 45 day period for consideration of the terms of and my participation in the voluntary early retirement program for the University of Arkansas. I further state that:

I have voluntarily sought this agreement on my own initiative;

I have been apprised of my rights under the Age Discrimination in Employment Act; and

I have been advised and have had the opportunity to seek the advice and counsel of attorneys, accountants, and others who could aid me in making an informed decision regarding the terms of my early retirement agreement.

_________________________________    ____________
Faculty Member                        Date
PURPOSE

The purpose of this policy is to establish and define an Employee Assistance Program (EAP) for the University of Arkansas for Medical Sciences (UAMS), and to notify departments and employees within UAMS of the procedures to be followed in accessing the services of the program. The EAP is a worksite-based program designed to assist in the identification and resolution of personal problems of employees including, but not limited to health, marital, family, financial, legal, emotional, stress, alcohol, drug, or other human concerns which may adversely affect employee job performance.

POLICY

All UAMS employees are eligible to participate in the Employee Assistance Program (EAP). On occasion, members of employee's families may participate in the program when activities are related to employee problems. Participation in the EAP is voluntary. Choosing to participate, or not to participate, will neither adversely affect an employee's job security and promotional opportunities, nor excuse an employee from adherence to UAMS policies and procedures concerning job performance and basic code of conduct. Contact with the EAP shall be confidential, except through written authorization by the employee, or in cases of an abused person, an unexplained, unusual or suspicious death, or a threat to one's own life or that of another, as prescribed by state and federal law 1. EAP records will be retained within the offices of the EAP, and will not become part of, or referenced to any employee's personnel file, medical file, or other file which may be accessed by any other department or organization. Visits to the EAP by an employee may be made during work hours while the employee is on UAMS time but must be coordinated through the employee's supervisor.

PROCEDURE

(1) The specific core activities of the Employee Assistance Program (EAP) include:

   a) Expert consultation and training of appropriate persons in the identification and resolution of job performance issues related to the personal concerns identified above;

   b) Confidential, appropriate and timely problem assessment and resolution services including referrals for appropriate diagnosis, treatment and assistance, establishment of linkages between the workplace and community resources that provide such services, and follow-up assistance to employees who use those services.

(2) Referrals to the Employee Assistance Program may be made by the employees themselves on a voluntary basis, or by the employee's supervisor when an employee's work performance has declined or basic code of conduct of an employee has not met acceptable standards as defined by UAMS Policy 4.4.01. However, the decision to accept a supervisor referral to the EAP program and subsequent referrals for treatment are voluntary, and are the personal responsibility of the employee.

(3) UAMS employees or members of their families requesting an appointment with the Employee Assistance Program should contact the EAP Office at 686-2588. Normal appointments will be scheduled within 72 hours when at all possible. Response to emergency situations will be scheduled within 24 hours, if possible. Employees seeking assistance from the EAP are encouraged to do so before job performance is impaired. Problems treated early are usually simpler to resolve.

(4) Usual working hours of the EAP are Monday through Friday, 8:00 am to 6:00 p.m. After hours or on weekends and during holidays, an answering service will provide access to the EAP. EAP is available 24 hours a day, 7 days a week for emergency situations.
(5) The services of UAMS' Employee Assistance Program are free. Employees referred to an outside provider however, will be responsible for all costs associated with those outside services; although the employee's medical insurance may cover part of the cost of those services.

(6) All UAMS departmental supervisors will complete EAP Supervisor's Training, provide orientation on EAP to their employees, and make all information concerning EAP available to those employees.

REFERENCE

1 United States Statute 42 CFR, Part 2
Arkansas Act 1208 of 1991, Section 3
Arkansas Rules of Evidence 503D1
PUBLISHER: UAMS ADMINISTRATIVE GUIDE

NUMBER: 4.4.01
DATE: 08/10/00
REVISION:

SECTION: HUMAN RESOURCES
AREA: EMPLOYEE RELATIONS
SUBJECT: BASIC CODE OF CONDUCT

PURPOSE

The purpose of this policy is to notify departments within the University of Arkansas for Medical Sciences (UAMS) of the procedures to be followed in establishing and communicating a basic code of conduct for all employees. The code is necessary to communicate to all UAMS employees the University’s expectations governing employee conduct. It is the responsibility of the department directors and supervisors to fully explain the following procedures to employees, to discuss their specific application within their departments, and to assure that they are observed. Appropriate disciplinary measures must be taken in cases where there have been violations of this Code of Conduct.

PROCEDURE

1. Employees should discuss patient and employee information with authorized personnel only, and in private.
2. Employees are expected to wear their identification badges while on duty.
3. Employees must refrain from using abusive, provocative or profane language, and should avoid creating or being party to a disturbance or physical violence.
4. Employees should observe the principle of mutual respect in their contacts with patients, visitors and students, and in their working relationships with faculty and other employees.
5. Employees should refer to Policy 4.4.09, Ethical Conduct/Gift Policy, regarding gratuities, gifts or personal favors from vendors, patients or visitors.
6. Employees finding property on the University premises must deliver such property to the Public Safety Department where a lost and found service is provided.
7. Employees must follow, within the definitions of the job description, all oral and posted work assignments.
8. Employees must maintain regular and punctual attendance. Departments should follow instructions for reporting absenteeism from work.
9. Employees must not report to work or be on the University premises if under the influence or odor of intoxicating liquor or controlled substances not prescribed by a physician.
10. Employees must obtain permission from their supervisors when it becomes necessary to leave their work areas during working hours.
11. Employees must accurately record their working time, and employees may not record work time of other employees.
12. Employees are expected, whenever possible, to respond to work assignments outside of regularly scheduled hours as may be necessary to provide essential staffing or support services.
13. Because of the large volume of hospital business transacted by telephone, outgoing personal telephone calls are not permitted on University telephones; and, the number of incoming calls must be limited to those of an urgent nature.1
14. Employees must make all packages, handbags, purses, totebags, briefcases, shopping bags or other containers being brought into or taken from the University buildings available for inspection upon request by supervisors or the Public Safety Department.
15. Employees should assist in keeping University equipment, buildings and grounds clean, orderly and in good condition, and should avoid creating or contributing to unsanitary or unsightly conditions.
16. Employees in certain positions are expected to wear prescribed uniforms while on duty. Department directors are responsible for informing employees of specific requirements.
17. Employees are strictly forbidden from sleeping on the job, except while on on-call status.
18. Employees are strictly forbidden from stealing, misappropriating or removing from University premises any property belonging to patients, visitors, students, contractors, or other employees of the University. This includes the removal of University property that has been discarded, and sample products.
19. Employees must not enter inaccurate or false information on any University or hospital records, including patient records, time records, employment applications or other personnel records.

http://uams.edu/AdminGuide/WIN04401.html

11/1/2005
20. Employees must not, under any circumstances, bring unauthorized firearms or weapons of any kind onto the University premises.

21. Employees must always use or operate University property and equipment in a safe and proper manner. Making equipment inoperative or failing to use safety devices can result in injuries to employees or others.²

22. Employees should not engage in horseplay, scuffling, running, throwing objects, or immoral or indecent behavior on the University premises.

23. Employees may engage in solicitation and/or distribution of printed or written material or posting and/or removal of notices or signs only when permitted or authorized in advance to do so.

24. Employees must observe safe work practices and published safety rules.

25. Employees may smoke only in designated areas.³

26. Employees are expected to know and observe established fire and emergency procedures.

27. Employees should not have other employees or guests visit them in work areas.

28. Employees who are not on duty should not be on the University premises, except for valid reasons.

29. Employees must not commit any criminal act on the University premises, or against employees, patients, visitors or students.

30. Employees, when purporting to represent the University, must accurately and honestly represent themselves and their positions to patients, visitors, students, other employees and the general public, and must not use another employee's identification badge.

31. Employees should use only authorized University entrances and exits.

32. Employees should use UAMS property for authorized purposes only.

REFERENCE

¹ UAMS Policy 3.1.03
² UAMS Policy 11.4.01 and UAMS Policy 11.4.15
³ UAMS Policy 3.1.01
PURPOSE

To provide UAMS and its employees legal and ethical guidelines regarding the propriety of accepting gifts.

SCOPE

This policy applies to all employees of UAMS. This policy does not apply to institutional donations.

POLICY

Principles of Ethical Conduct

The following principles of ethical conduct apply to all employees of UAMS:

Public service is a public trust, requiring employees to place loyalty to the laws and ethical principles above private gain.

Employees shall not engage in financial transactions using non-public information or allow the improper use of such information to further any private interest.

An employee shall not, except pursuant to the exceptions in A.2 and A.4, solicit or accept any gift or other item of monetary value from any person or entity seeking treatment from, or doing business with UAMS.

Employees shall put forth honest effort in the performance of their duties.

Employees shall make no unauthorized commitments or promises of any kind purporting to bind UAMS.

Employees shall not use their position for private gain.

Employees shall act impartially and not give preferential treatment to any private organization or individual.

Employees shall protect and conserve UAMS property and shall not use it for other than authorized activities.

Employees shall not engage in outside employment or activities, including seeking or negotiating for employment, that conflict with their UAMS duties and responsibilities.

Employees shall disclose fraud, abuse and corruption to appropriate authorities.

Employees shall endeavor to avoid any actions creating the appearance that they are violating the law or these Standards of Ethical Conduct.

Basic Concepts

Employees shall apply the principles stated above in weighing the propriety of conduct not otherwise addressed in this policy.

PROCEDURE
A. Gifts from outside sources.

1. A UAMS employee shall not solicit or accept a gift:
   a. from a patient, visitor or a person or entity that contracts with, does business with or seeks to do business with UAMS; or
   b. given because of the employee's official position.

2. The term "gift" includes almost everything of monetary value, but NOT these:
   a. coffee, donuts, and similar modest items of food and refreshments when offered other than as part of a meal;
   b. greeting cards and most plaques, certificates and trophies;
   c. rewards and prizes in contests open to the public;
   d. commercial discounts available to the general public or to all government or UAMS personnel;
   e. commercial loans, and pensions and similar benefits;
   f. anything for which the employee pays market value.

3. Employees in purchasing, billing, collections, financial offices and offices otherwise engaged in contracting for expenditure or receipt of funds shall not solicit or accept gifts from persons or entities that contract with, do business with or seek to do business with UAMS.

4. There are certain limited exceptions where gifts may be accepted by UAMS employees other than those described in No. 3 above. Such employees may accept the following:
   a. unsolicited gifts with a market value of $25 or less per occasion, so long as the total value of all gifts received from a single source during a year does not exceed $100;
   b. gifts based on an outside relationship, such as a family relationship or personal relationship;
   c. discounts and similar benefits offered to groups in which membership is not related to UAMS employment (or "government discounts" where the same offer is broadly available to the public through similar groups), and certain benefits offered by professional associations or by persons who are not prohibited sources (A.1.a. above);
   d. legitimate awards that are part of a regular and established program of recognition for meritorious public service;
   e. gifts resulting from the outside business activities of employees and their spouses;
   f. free attendance provided by the sponsor of a widely-attended gathering, speaking engagement, or other event where UAMS has determined it is in its best interest to attend the event;
   g. food, refreshments, and entertainment at certain social events extended by persons who are not prohibited sources, where no one is charged a fee to attend the event;
   h. unsolicited gifts for free attendance for UAMS employees (and spouses) at events sponsored by state or local governments or non-profit, tax exempt civic organizations, where UAMS has determined it is in its community relations interests to attend the event.

5. Travel to attend training or other events where UAMS has determined it is in its interest to attend the event may only be accepted under the following conditions:
   a. The cost of travel to and from the event and lodging during the event may only be accepted upon the approval of the Department Chair, Director or Dean.
   b. Meals, social events and other gifts are subject to the $25/$100 limitation described in 4.a. above.
   c. Employees shall not accept any payment as "compensation" for their time or any out-of-pocket expenses except for honoraria or consultation fees for actual services rendered, when appropriately disclosed and approved, and not otherwise prohibited.

6. Even if a gift is covered by one of the exceptions, do not accept it if it will undermine the integrity of UAMS.
   a. An employee may not use his/her official position to solicit a gift or force someone to give a gift.
   b. Gifts may not be accepted so frequently that anyone would question whether influence is being bought.
c. Any gift is illegal if it is in exchange for an official action.
d. Some gifts may be prohibited by other statutes.

7. Handling Improper Gifts. When an employee cannot accept a gift:

a. First and foremost, if possible, refuse the offer of an improper gift. Diplomatically explain that UAMS employees may not accept certain gifts.
b. The employee should pay the donor its market value; or
c. If the gift is a tangible item, the employee may instead return the gift.
d. Subject to approval, perishable items may be donated to charity, shared with the office or destroyed.
PURPOSE

The purpose of this policy is to maintain the research credibility of the faculty, staff and the University of Arkansas for Medical Sciences campus so that there will be public confidence in scientific research and any injury to the public interest will be avoided. It is recognized that, as is the case with all human endeavors, honest mistakes will occur in the conduct of scientific research. Therefore, investigators who inadvertently make errors in either the planning, execution or interpretation of scientific research shall not be considered in violation of the policy contained within this document.

POLICY

It is the policy of the University of Arkansas for Medical Sciences (UAMS) that all scientific research engaged in by faculty and staff of this campus must be conducted, and the results reported, with integrity. Indicated research must have actually been performed. Data must be verified and academic honesty must prevail. Research findings must be fairly attributed as to their authors. Research results are to be documented and comply with federal requirements that uniquely relate to the conduct of that research. The following conduct, which this policy addresses, constitutes scientific misconduct and includes, but is not limited to:

a. Knowingly misrepresenting or falsifying research data.
b. Intentionally concealing actual facts material to research results reported, or falsely representing actual facts discovered which are material to research results reported.
c. Filing research reports and/or publishing research findings without having done the research indicated.
d. Falsely claiming to be the author of research which was performed by others.
e. Deceitfully reporting research of others as one's own and/or plagiarism involving the work of others.
f. Material failure to comply with federal requirements that uniquely relate to the conduct of research. This would include, but not be limited to, failure to comply with federal requirements for protection of human subjects or for ensuring the welfare of laboratory animals.

Research at UAMS is expected to be conducted with full regard for the academic freedom of those so involved, and with the responsibility for insuring that the intentional perversion or suppression of truth does not compromise scientific research in the medical sciences. Scientific misconduct undermines the methods and purposes of those scientists using acknowledged research methods.

Principal investigators and laboratory directors are ultimately responsible for the supervision and verification of research programs and personnel in their laboratories. This responsibility includes the maintenance of accurate and reliable records and data, the preparation of quality research papers, and the assurance that the authors of papers have actually contributed to the research efforts reported.

A charge of scientific misconduct is a most serious charge. For that reason, the Vice Chancellor, the review committees and all others involved in the inquiry or investigation shall take whatever actions are necessary to protect, to the maximum extent possible, the privacy of those who, in good faith, report apparent misconduct. In addition, the Vice Chancellor, the review committees and all others involved in the inquiry shall afford the affected individual(s) confidential treatment to the maximum extent possible. Further, should the charge not be sustained, formal and extensive efforts are to be made so that the reputation of the person against whom the charge was made shall not be impaired. Charges made maliciously and in bad faith, after so found, shall lead to employee disciplinary action.

PROCEDURE (GENERAL)

1. Initial reports that scientific misconduct may have occurred are to be made to the Vice Chancellor for Academic Affairs, hereafter referred to as the Vice Chancellor. The Vice Chancellor must then inform the Dean(s) of the College(s) of the person making the initial report and of the person so charged. In certain instances, others, as required by law, regulation or contract, may also be notified at this
PROCEDURE (INITIAL INQUIRY)

2. The initial inquiry of the charge that scientific misconduct may have occurred must be by an internal review panel of full time UAMS faculty members, termed the Inquiry Committee. This inquiry must be completed within 60 calendar days of its initiation, i.e., from the time of receipt of the initial allegation by the Vice Chancellor, unless circumstances clearly warrant a longer period. If the inquiry takes longer than 60 days to complete, the record of the inquiry must include documentation of the reasons for exceeding the 60 day period.

3. The Vice Chancellor, in consultation with the Dean of the person so charged, must prepare a list of potential committee members from the UAMS faculty roster, making every effort in the selection process to form an Inquiry Committee with the appropriate scientific expertise. This list must be presented to the person so charged and he/she may request that any potential member not be impaneled by submitting to the Vice Chancellor a written explanation of why the person(s) should not serve on the committee. The Vice Chancellor, in consultation with the Dean of the person so charged, must decide on the validity of the challenge to any potential committee member, and choose six members to serve as the Inquiry Committee. Once formed, the Inquiry Committee must elect one of its members to assume the role of chairman.

4. The members of the Inquiry Committee must have no real or apparent conflict of interest and will be asked to sign a statement to this effect. Any relationship with the involved parties must be disclosed to those involved in the inquiry. Any member of the Inquiry Committee with a conflict of interest must be replaced with a member selected by the Vice Chancellor.

5. The Vice Chancellor is to be present in a non-voting capacity at all Inquiry Committee meetings to provide procedural advice to the committee. At his/her discretion, the Dean or his/her designee of the College of the charged person may also be present in a non-voting capacity. The person giving testimony to the committee and the above noted exceptions may be present in any meeting. Legal counsel may not be present during meeting of the Inquiry Committee.

6. The Inquiry Committee shall make an inquiry of the evidence which may include interviewing persons with relevant information. An inquiry means information gathering and initial fact finding to determine whether an allegation or apparent instance of misconduct warrants an investigation. Once the inquiry is initiated, the charged person is obligated to cooperate by providing material necessary for the proceedings of the Inquiry Committee. Failure to do so may result in immediate Investigative Review (See UAMS Policy 12.1.04, Procedures 10-18) or other institutional sanctions.

7. At the conclusion of the inquiry, the Inquiry Committee must decide, by a majority vote, whether an investigation into the allegation of the scientific misconduct is warranted. The committee must prepare a written report that states what evidence was reviewed, summarizes relevant interviews, and includes the conclusions of the inquiry. This report must provide sufficiently detailed documentation of the inquiry to permit a later assessment of the reasons for determining that an investigation was not warranted, if necessary. This inquiry report must be forwarded to the Vice Chancellor, Dean of the person charged, and the individual(s) who made the allegation. The person charged with scientific misconduct may comment on the report, and his/her comments will be made part of the record.

8. All records must be maintained in a secure manner in the Office of the Vice Chancellor for a period of at least three years after the termination of the inquiry, and must, upon request, be provided to authorized personnel as required by law, regulation or contract.

9. If the Inquiry Committee finds that an investigation into the allegation of scientific misconduct is not warranted, the Vice Chancellor, and all other persons involved, must, to the maximum extent possible, take steps to minimize the damage to reputations which may result from inaccurate reports.

PROCEDURE (INVESTIGATIVE REVIEW)

10. If the Inquiry Committee finds that an investigation is warranted, the Vice Chancellor must initiate the investigation by impaneling an Investigative Committee within 30 days of receiving the report of the Inquiry Committee. This investigation should ordinarily be completed within 120 days of its initiation. However, if this deadline cannot be met and the project(s) involve federally-funded research, then a written request for an extension must be submitted to the appropriate office as required by federal regulations.

11. The Vice Chancellor, in consultation with the Dean of the person so charged, must prepare a list of potential committee members, making every effort in the selection process to form an Investigative Committee with the appropriate scientific expertise. This list must be presented to the person so charged and he/she may request that any potential member not be impaneled by submitting to the Vice Chancellor a written explanation of why the person(s) should not serve on the Committee. The Vice Chancellor, in consultation with the Dean, will then decide on the validity of the challenge to any potential committee member.

12. The Vice Chancellor must appoint an Investigative Committee. It is to consist of six members, at least four of whom are full-time faculty members of UAMS at the rank of associate or full professor. Up to two scientists who are not employees of the University of Arkansas for Medical Sciences, each of whom must be personally qualified to judge the scientific nature of the research work, may also be appointed to the Committee. Once formed, the Investigative Committee must elect one of its members to assume the role of chairman.

13. The members of the Investigative Committee must have no real or apparent conflict of interest and will be asked to sign a statement to this effect. Any relationship with the involved parties must be disclosed to those involved in the investigation. Any member of the Investigative Committee with a conflict of interest must be replaced with a member selected by the Vice Chancellor.

14. The Vice Chancellor is to be present in a non-voting capacity at all committee meetings to provide procedural advice to the committee members. At his/her discretion, the Dean or his/her designee of the college of the charged person may also be present in a non-voting role.
capacity. Legal counsel or another advisor may be present during meetings of the Investigative Committee in which the person so charged is interviewed to provide advice but may not address the committee. Only the person giving testimony to the committee, and the above noted exceptions, may be present in any committee meeting.

15. The Investigative Committee shall investigate fully to determine if scientific misconduct, as defined by this policy, has occurred. In doing so, it may utilize any files developed by the Inquiry Committee and may review any additional evidence deemed relevant through procedures adopted by the panel. The Committee must secure necessary and appropriate expertise to carry out a thorough and authoritative evaluation of the relevant evidence. The investigation normally will include examination of all documentation, including, but not necessarily limited to, relevant research data and proposals, publications, correspondence, and memoranda of telephone calls. Whenever possible, interviews should be conducted of all individuals involved either in making the allegation or against whom the allegation is made, as well as other individuals who might have information regarding key aspects of the allegations. Complete summaries of these interviews should be prepared, provided to the interviewed party for comment or revision, and included as part of the investigatory file. All involved parties are obligated to cooperate fully with the proceedings of the Investigative Committee. Funding agencies must be kept apprised of developments during the course of the investigation, as required by law, regulation or contract.

16. The Investigative Committee must determine, by a majority vote of its members, whether scientific misconduct has been proven by a preponderance of the evidence, and if so, must recommend sanctions.

17. The Investigative Committee must provide a written report of its findings to the Vice Chancellor, the Dean(s) of the person charged and the person making the charge, the person making the charge, the person(s) so charged and others to the extent required by law, regulation or contract. The report shall include the documentation which supports the committee’s findings. Only the Vice Chancellor may release a copy of this personnel determination to third parties. Reports from the Investigative Committee must, otherwise, remain confidential and must be secured in the Office of the Vice Chancellor. All records must be maintained for a period of at least three years after the termination of the investigation.

18. If the Investigative Committee does not find that scientific misconduct has occurred, the Vice Chancellor must, to the maximum extent possible, take steps to minimize the damage to reputations which may result from inaccurate reports.

PROCEDURE (APPEALS PROCESS)

19. The decision of the Investigative Committee may be appealed. Appeals are made to the Chancellor of UAMS and must be filed within seven days of the Investigative Committee's decision. Any such appeal will be limited to the evidence presented during the investigative review and the grounds for appeal are limited to failure of the Investigative Committee to follow appropriate procedures or that an arbitrary decision was made. New evidence contained within the appeal may warrant a reopening of the investigation. The decision of the Chancellor is final.

PROCEDURE (SANCTIONS)

20. If the Investigative Committee finds that scientific misconduct has occurred, the Vice Chancellor and the Dean of the person so charged, with due consideration of the recommendation of the Investigative Committee, must recommend to the Chancellor sanctions to be imposed. The Chancellor must then impose sanctions in accordance with UAMS personnel policies after the conclusion of the appeals process.

PROCEDURE (FEDERAL POLICY)

21. The Vice Chancellor must notify the Office of Scientific Integrity (OSI), in accordance to Federal Policy (Federal Register 54:32450, 50.103d) when, on the basis of an initial inquiry, the institution determines that an investigation is warranted, or, prior to the decision to initiate an investigation, if any of the following conditions exist:

   a. There is an immediate health hazard involved.
   b. There is an immediate need to protect Federal funds or equipment
   c. There is an immediate need to protect the interests of the person(s) making the allegations or of the individual(s) who is the subject of the allegations as well as his/her co-investigators and associates, if any.
   d. It is probable that the alleged incident is going to be reported publicly.
   e. There is a reasonable indication of possible criminal violation. In that instance, the Vice Chancellor must inform the OSI within 24 hours of obtaining that information.

REFERENCE

1 UAMS Policy 12.1.03
EXTRA COMPENSATION POLICY

Purpose

In accomplishing its mission, the University's greatest resource is its personnel. The purpose of this policy is to provide flexibility, within appropriate guidelines, in order to permit the most effective use of the time and talents of University personnel.

Assumptions

1. The salary of a full-time employee of the University is intended as compensation for all regularly assigned activities performed for or in the name of the University.

2. An employee may be called upon from time to time to perform additional tasks over and above regularly assigned duties for which he or she may receive extra compensation.

Restrictions

1. An employee must be certified by his or her dean or supervisor as working a full load in addition to the activity for which extra compensation is being recommended.

2. The work for extra compensation shall not interfere with the regular duties of the individual, as certified by the dean or supervisor.

3. The request for extra compensation should be approved by the dean or equivalent officer in advance of performance of the work.

4. Federal funds may not be used to pay extra compensation unless specifically authorized by the sponsoring agency.

5. Extra compensation for an individual must be consistent with any applicable state and federal laws and regulations and with any applicable accreditation standards or criteria.

6. Extra compensation must not result in a conflict of interest.

7. University funds will not be used for extra compensation for speeches, public appearances, etc., which are civic, public relations, or development activities.
8. University funds will not be used for extra compensation for such scholarly activities as research, research consultation and collaboration, or creative works considered part of normal faculty duties.

9. The institutional policy that an employee may not through extramural funding achieve a raise in his or her base annual salary is here reaffirmed.

10. An employee's total compensation, for a year or for a month, including extra compensation, shall not exceed the maximum salary as provided in applicable state statutes. A change of title will not be approved in order to pay an individual above his/her existing line item maximum.

11. Full-time employees may receive for extra compensation with preparation for and time in class falling outside their regular work schedules.

12. Senior administrators, as defined by the Chancellor, shall not be eligible for extra compensation for teaching a class or performing other duties for the University.

13. Stipend for extra compensation must be authorized to be paid at the regular payroll period for the time period in which it is earned.

Procedure

1. Each campus or unit within the University of Arkansas shall establish procedures to receive recommendations for extra compensation. Each campus or unit will monitor extra compensation for conformity to the requirements of this Administrative Memorandum. Each Chancellor or equivalent officer shall approve each request for extra compensation. Information regarding extra compensation shall be maintained for an annual report.

2. The maximum amount which may be paid to an employee is twenty (20) percent of his/her annual salary, in accordance with restriction number ten (10).

3. Exceptions to the provisions of this policy will require the approval of the President.

August 7, 1995 (Revised)
February 6, 1984 (Revised)
September 4, 1979 (Revised)
January 1, 1979 (Revised)
October 4, 1978 (Revised)
November 17, 1975
PURPOSE

The purpose of this policy is to inform all departments within the University of Arkansas for Medical Sciences (UAMS) of the requirements to be followed in the use of Honorariums. An Honorarium is defined as a payment or reward in recognition for gratuitous or professional services on which custom or propriety forbids any fixed business price to be set. It includes payments to persons such as guest speakers and lecturers.

PROCEDURE

1. Departments requesting payment of an Honorarium must complete an Honorarium Approval Form. Original copies of this form may be obtained from the UAMS Distribution Center.
2. The completed Honorarium Approval Form must be faxed or mailed to the buyer. An on-line requisition must be sent to the buyer and the requisition number referenced on the Honorarium Form.
3. An Honorarium is a special category of payment and is not to be used in lieu of regular travel payments. Persons invited to the University to interview for a position on the faculty or staff should be reimbursed on a purchase order.
4. Honorarium payments in excess of $5,000, excluding reimbursable expenses, require the use of Professional and Consultant Service Contracts. Payments in excess of $5,000 must be noted as sole source and the PCS form located on the website: http://ss.uams.edu/contract/forms/pcscontract.pdf should be completed and forwarded to Contract Services.

HONORARIUM INSTRUCTIONS

COMPLETING THE FORM

1. Date: Enter the date of the request.
2. Request approval of: Enter the name, address, and social security number of the person to be paid an honorarium.
3. To Appear For The Purpose of: Describe the reason and/or occasion for which the person will appear.
4. On The Following Dates: Enter the dates, inclusive of all days the person is to appear.
5. For This Service the University Agrees To Pay As Follows: Enter the amount that the UAMS has agreed to pay.
6. Approval Recommended: The Director, or his designee, of the responsible department must sign in this space showing approval of the request.
IMPLEMENTATION OF BOARD OF TRUSTEES POLICY ON POLITICAL ACTIVITY

An employee of the University who becomes a candidate for any national or statewide office will be placed on Leave of Absence Without Pay at the time of filing. An employee who becomes a candidate for the Arkansas General Assembly or a county office will have his/her employment status and salary reduced to half-time at such time after filing that he/she has an opponent who has filed. (In primary elections this means an opponent with the same political party designation.) Such leave will extend to the end of the semester or summer session in which the election is held. An employee who has an opponent in the general election must take similar leave for the fall semester.

An employee who is elected to a full-time county, statewide or national office will be granted a Leave of Absence Without Pay for one year, and at the discretion of the Board of Trustees for a second year. In no instance will the leave be extended beyond the end of the second year. Employees elected to the Arkansas General Assembly must take Leave of Absence Without Pay when the General Assembly is in regular session and for the duration of extraordinary sessions.

February 13, 1976
LUMP SUM TERMINAL PAY

When an individual ceases to be an employee of the University, any unused annual leave as of his/her last duty date shall be liquidated by a lump sum payment not to exceed thirty working days, inclusive of holidays.

Accrued unpaid leave shall be calculated as follows: divide the annual salary rate (or twelve times the monthly salary rate) by 250 to obtain the daily rate; multiply the daily rate by the number of days of accrued unpaid leave (to a maximum of thirty days). This shall be the amount of lump sum payment due for unused leave.

Final payment shall include all monies due up to and including the last day of work, which shall be the employee's date of termination.

The position being vacated may be filled on the day following the date of termination, provided all aspects of the University's Affirmative Action and Equal Employment Opportunity Plans have been met.

March 7, 1980 (Revised)
April 9, 1976 (Revised)
November 17, 1975
POLICY

It is the policy of the University of Arkansas for Medical Sciences (UAMS) that the UAMS Office of Communications and Marketing oversees all publicity, advertising and communications regarding clinical as well as all other areas of campus. All requests for publicity or interviews should be channeled through the Office of Communications and Marketing.

PROCEDURE

1. Newspaper and television photographers, reporters or other members of the working press are not permitted in the Emergency Room, on patient floors in the hospital, in outpatient areas or in any clinical areas on the UAMS campus unless their visits are first cleared with the Office of Communications and Marketing. This applies to all clinical areas including the Hospital, the Arkansas Cancer Research Center, the Outpatient Center, the Community Women's Center and the Harvey and Bernice Jones Eye Institute, the Stephens Spine and Neurosciences Institute and the Myeloma Institute. All members of the media must also be accompanied by a representative of the Office of Communications and Marketing while on UAMS property.

2. Because many members of the UAMS medical and professional staffs have well-established reputations for expertise in their areas of interest, they may receive calls from the press to obtain information for articles. If these requests involve their work as members of the faculty or staff at UAMS, these requests should be referred to and coordinated by the Office of Communications and Marketing. A representative of the Office of Communications & Marketing should be present at any interviews which take place. If there are any questions or concerns regarding UAMS policies or procedures in providing information, they should be referred to the Office of Communications and Marketing. Other employees should refrain from acting in a spokesman's capacity unless requested to do so.

3. Any non-routine request for information from the media concerning the Hospital or clinical programs received by either Hospital Administration or Nursing Administration must immediately be shared with the Office of Communications and Marketing.

4. To protect a patient's privacy rights, and to ensure the accuracy of any information provided to the media, only designated individuals in the Office of Communications and Marketing, Hospital Administration and Nursing Administration are authorized to release to the press any information concerning patients and their conditions. Patient information, including acknowledgment of a patient's presence at UAMS, will not be provided to the media unless the patient has chosen not to opt out of any part of the patient directory. If the patient has not opted out of any part of the patient directory, and the media ask for the patient by name, only a one-word description of the patient's condition may be released, unless the patient has otherwise asked us not to release such information or the Office of Communications and Marketing, Hospital Administration or Nursing Administration elect not to release any information. In the event of a patient's death, no information regarding the death of a patient will be released to the news media prior to the notification of next-of-kin or other legal representative.

5. Any additional release of information regarding the patient, beyond the one-word statement of condition, requires
written authorization from the patient or the patient's legal representative. If such authorization is obtained, a designated UAMS representative may release information authorized in writing by the patient; however, the information released shall be confined to that of a general nature. A copy of the patient's signed authorization must be kept on file with Hospital Administration, and the signed authorization must meet the requirements for a valid authorization as set forth in the HIPAA regulations. The UAMS Authorization for Release of Information to the Media form must be utilized.

6. Wallet-sized cards detailing simple guidelines for dealing with the media are available by contacting the Office of Communications and Marketing. It is also recommended that each physician and department head undergo a short training course for dealing with the media. This can be scheduled through the Office of Communications and Marketing at 686-8990.

7. Requests to all employees, medical staff and house staff for information from media representatives should be referred to the area listed below, depending on when the request is received:

   a. Weekdays - Requests received on a weekday (Monday through Friday, 8:00 a.m. to 4:30 p.m.) should be referred to the Office of Communications and Marketing, 686-8998 or pager 395-5989.
   b. Evenings, Nights and Weekends - Requests received during evenings, nights and weekends should be referred to the Assistant Director of Nursing on duty, at (501) 686-7000 or to the Office of Communications and Marketing at pager 395-5989. Whichever one receives the notification should inform the other of the media request.
   c. If a request for information cannot be referred to either Communications & Marketing or the Assistant Nursing Director on duty, the Administrator on call should be contacted.

8. Any non-routine request for information received by either Communications & Marketing, Hospital Administration, or Nursing Administration should be shared immediately with the other three offices.
UNIVERSITYWIDE ADMINISTRATIVE MEMORANDUM

Outside Employment of Faculty and Staff Members for Compensation

While emphasizing the fact that full-time faculty and staff members of the University are obligated to devote their working time and efforts primarily to University duties, the University recognizes that a limited amount of outside work for private compensation may be advantageous to all concerned. Such persons are therefore encouraged to engage in outside employment which will affirmatively contribute to their professional advancement or correlate usefully with their University work. This employment should not interfere in any substantial way with the employee's University duties nor conflict with his scheduled University assignments. Written approval from department head and dean should be obtained in advance of such outside employment. Each dean or similar officer shall keep records on outside employment by personnel in his college, and such records shall be reviewed periodically by the chief academic officer on each campus. The employee shall always make it clear the outside employment is his own responsibility and that in it he does not act as an agent or representative of the University. University property or facilities shall not be used except with permission of the employee's department head or other superior, and the payment of appropriate fees therefore may be required.

The attached form is to be used to report outside activities to the chief academic officer. It is due annually on August 1.

August 28, 1978
### Annual Report on Outside Employment of Faculty/Administrative Staff Members for Compensation

#### Fiscal Year 2004/2005

**College/Administrative Unit:** ____________________________

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<th>Name</th>
<th>Rank/Title</th>
<th>Department</th>
<th>Period of Employment</th>
<th>Est. Hrs. Per Month</th>
<th>Amount of Compensation</th>
<th>Approval Date</th>
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Policy on Conflict of Interest and Conflict of Commitment

- **PURPOSE**
The purpose of this document is to define and to provide guidelines for the management of potential conflicts of interest or commitment on the part of faculty and academic staff, and further to promote objectivity in research by establishing a framework to ensure that the design, conduct, and reporting of research will not be biased by any conflicting financial interests of individuals or the institution.

- **INTRODUCTION**
Aiming for excellence in its missions of education, research, and clinical service, the University of Arkansas for Medical Sciences (UAMS) seeks continuing development of the knowledge, skills and expertise of its faculty. To this end, the university encourages faculty and academic staff to pursue outside activities which contribute to personal and professional growth and development. Further, the reservoir of skills and expertise and the new knowledge created can add substantial value to the common good and welfare through outside activities.

In the pursuit of such goals, there may inevitably arise conflicts between the demands of external activities and the primary obligations to UAMS activities. Moreover, the involvement in multiple enterprises may offer opportunities for divergence of personal or private interests from those of UAMS. In UAMS activities funded in whole or in part by external sponsors, there may be occasion for yet further conflicts of interest, and UAMS has an institutional responsibility to ensure compliance with the guidelines of the sponsor.

Some external activities or interests may be so far removed from the UAMS roles and responsibilities of the individual that the only considerations become those of impact on the time and energy available for primary university duties. Other external interests may not divert any energy from university duties but may introduce concerns about possible impact on objectivity in university-related activities. Still other activities may introduce both types of concerns. Since a single disclosure mechanism may support the management of both types of consideration, and because of the overlap in some activities, both types of conflicts are addressed in this policy.

This policy deals with general principles, procedures for disclosure and administrative review of potentially conflicting interests or commitments, guidelines for management of unavoidable conflicts, and administrative actions and appeals.

- **GENERAL PRINCIPLES**
Arrangements relating to external activities by faculty should never be allowed to undermine the basic missions of UAMS and should be specifically constrained to minimize distraction from primary obligations to UAMS and to minimize placing either the individual or UAMS in a position of having or appearing to have a conflict of interest. Such conflicts of commitment and conflicts of interest as arise must be managed according to appropriate guidelines.

**Obligation to the University.**
Faculty members must demonstrate primary professional loyalty to UAMS and devote themselves to teaching, caring for patients, interacting with students, carrying out research and
scholarly work, serving on appropriate campus committees, performing administrative duties, and other required functions. With an acceptance of a full-time appointment to the UAMS faculty, an individual makes a commitment to UAMS (and to the appropriate hospital, if part of a hospital-based department) which is full-time in the most inclusive sense.

**Professional Growth.**
The institution currently applies the generally accepted academic standard that affords faculty time, consistent with formally negotiated obligations, for extra-mural scholarly pursuits that relate to and advance professional growth and public service; however, any medical professional service is constrained by the MCPG By-Laws.

**Objectivity in Research.**
The fundamental values of the university include the highest standards of research integrity and objectivity. Thus, no conflict of interest on the part of academic staff members can be permitted to influence the design, conduct, or reporting of research.

**Technology Transfer.**
Appropriate transfer of technology can make the results of research more quickly available for the good of the public and can assist the state in commercial development and expansion of its economic base. Accordingly, efforts to commercialize or otherwise make quickly and widely available the results of new knowledge are encouraged.

- **GOVERNANCE**
  This policy is governed by Arkansas State Law and by policies of the University of Arkansas Board of Trustees and is subject to change as those laws and policies are amended. Nothing in this policy shall be construed to supersede state or federal laws or the University of Arkansas Board of Trustees policies. Further, some funding agencies may establish further restrictions or requirements that must be met. It is the responsibility of Principal Investigators to familiarize themselves with such policies. The Office of Research Administration shall maintain current knowledge of such policies in order to assist investigators.

- **DEFINITIONS**

  **Academic staff member.**
  An academic staff member is a faculty member or, with respect to research, the principal investigator, co-principal investigator, and any other person at UAMS who is responsible for the design, conduct, or reporting of research or educational activities. The definition includes anyone who is paid by or whose work is supported by a grant or contract from an external source and includes any member of the UAMS faculty or staff who is eligible to apply for federal or other grants. It specifically includes postdoctoral fellows, research associates or assistants, and graduate students.

  **Technology Transfer.**
  Technology transfer refers to the commercialization of ideas, concepts, and inventions through publication, patenting and licensing, and the formation of business entities.
**Conflicts of Commitment.**
The term "conflict of commitment" relates specifically to significant distraction of an individual academic staff member's attention or effort from obligations to the academic appointment (teaching, research, other services, and/or patient care) because of "outside" activities. The latter may include, but are not limited to, professionally-related and generally encouraged activities such as consulting, textbook authorship, involvement with professional societies, and participation in review panels. Such activities are usually expected of academic staff members to promote professional development and to enrich their contributions to the institution, their profession, and the community. Scientific consulting relationships, for example, may serve to create conduits for the exchange of information and technologies that enhance the university environment and permit academic staff to test the soundness of their ideas. Professional service activities on the part of College of Medicine faculty, such as patient care and professional consultation, are subject to special constraints as defined in the MCPG By-Laws.

Part-time faculty may not be subject to conflict of commitment guidelines due to the nature of their appointments; however they are subject to conflict of interest requirements, especially if they participate in sponsored activities. These instances should be discussed with individual chairs.

**Conflicts of Interest.**
A conflict of interest is defined as a divergence of interests away from professional obligations to the Institution or to external sponsors of research or other activities toward an individual's private or personal interests. Under these conditions, an unbiased observer would find it difficult to determine whether the individual's professional actions or deeds are determined by personal considerations of gain, financial or otherwise not in the best interest of the Institution and sponsor.

In particular, a conflict of interest exists in, but is not limited to, situations where a Significant Financial Interest could directly and significantly affect the design, conduct, or reporting of research.

**Immediate Family.**
The Immediate Family is defined to include spouse, domestic partner, and dependent children, as defined by the U.S. Internal Revenue Service.

**Significant Financial Interest.**
A Significant Financial Interest means anything of monetary value, including but not limited to, salary or other payments for services (e.g. consulting fees or honoraria); equity interests; (e.g. stocks, stock options or other ownership interests); and intellectual property rights (e.g. patents, copyrights and royalties from such rights). The term does not include:

- salaries, royalties, or other remuneration from UAMS;
- income from occasional seminars, lectures, or teaching engagements sponsored by public or nonprofit entities;
- income from service on advisory committees or review panels for public or non-profit entities;
- an equity interest that when aggregated for the Investigator and the Investigator's spouse and dependent children, meets both the following tests: Does not exceed $10,000 in value
as determined through the reference to public prices or other reasonable measures of fair market value, and does not represent more than a five percent ownership interest in any single entity;

- salary, royalties, or other payments from a single source that when aggregated for the Investigator and the Investigator’s spouse and dependent children over the next twelve months, are not expected to exceed $10,000.

**Responsible Administrator.**

With respect to the disclosure and management provisions of this policy, the term "Responsible Administrator" for an academic staff member refers, in the first instance, to the department chair of the person. For academic staff members not assigned to a department, or for department chairs, the Responsible Administrator is the dean. For deans, vice chancellors, or other university-wide officials, the Responsible Administrator is the chancellor or his/her designee. For purposes of second level review, the next higher administrator is responsible. The designated institutional official for purposes of supervising the broad operation of the system, protecting confidentiality and maintaining records and for assurances to providers of extra-mural support is the Vice Chancellor for Academic Affairs or, as his/her designee, the Director of the Office of Research Administration.

**DISCLOSURE AND REVIEW**

**Disclosure.**

Outside activities or Significant Financial Interests relating to the professional roles for which academic staff members are employed by UAMS must be disclosed annually to the Responsible Administrator by all UAMS faculty (Full and Part-time), using Conflict of Interest disclosure forms (Appendix 4). All Significant Financial Interests which are directly or indirectly related to the professional activities of the faculty member must be disclosed, as must any external commitment which might be perceived as presenting a conflict of commitment. Other academic staff members who are to participate in externally funded research must also disclose Significant Financial Interests and are also otherwise subject to this policy. See Definition 5.6 and Appendices 1 and 2 for requirements, examples, and exceptions.

Any cases of potential conflicts of interest which arise between reporting periods must be disclosed promptly in writing to the Responsible Administrator and to the chair of the Conflict of Interest Committee, using a Conflict of Interest Disclosure Form.

Disclosure forms are to be reviewed by the Responsible Administrator for possible conflicts before forwarding to the appropriate Dean and subsequently to the Vice Chancellor for Academic Affairs.

**Federal Grants.**

At the time of submission of a proposal for any federal grant, the principal investigator of that grant shall provide a verification of currency of disclosure of Significant Financial Interests for all academic staff members involved in the proposed work (Appendix 5), and in the event of an award shall be responsible for assisting in developing an assurance of management of conflicts of interest.
If federally funded research is to be carried out in part by subgrantees, contractors, or collaborators, the principal investigator is responsible for securing the compliance by such other investigators with this UAMS policy or for providing from the external entities assurances that will enable UAMS to comply with its institutional responsibilities to the funding agency.

Prior to expenditure of any funds from a federal award, the Office of Research Administration shall report to the awarding agency the existence of any conflicting interest with respect to the research proposed (but not the nature of the interest or other details) and assure that the interest has been managed, reduced, or eliminated. For any conflicting interest identified subsequent to the initial report under the award, a report shall be made and the conflict managed, reduced, or eliminated within sixty days.

**Maintenance of Records.**
All financial disclosures and records of actions taken by UAMS with respect to each conflicting interest shall be maintained for at least three years from the date of the submission of the final expenditure report for any federally funded project. Such information shall be provided to the funding agency upon appropriately authorized request.

**Conflict of Interest Committee.**
The Conflict of Interest Committee shall be appointed by the Vice Chancellor for Academic Affairs and shall be a standing committee of UAMS. The Chair shall be appointed by the Vice Chancellor for Academic Affairs, and the Committee shall meet regularly in order to act in a timely fashion. The Conflict of Interest Committee shall review disclosures for possible conflict and shall advise appropriate officials on the management of the situations. The Committee shall also publish and periodically revise concrete guidelines to assist faculty and administrators.

**Approval of Outside Employment.**
As outlined in University of Arkansas Board Policy 450.1, written approval must be obtained from the department head and/or Dean in advance of outside employment. All other provisions of that policy should be adhered to as well, including annual disclosure of such employment.

**Special Circumstances.**
Arkansas state law provides certain exemptions from prohibitions on activities of state employees that encourage facilitation of commercialization of university-generated technology or discovery. These exemptions from the state ethics law do not necessarily exempt an individual from any restrictions imposed by UAMS policy. In particular, UAMS policy requires full disclosure through the mechanism outlined in Section 6.1.

**Business Incubators.** Faculty or staff of state-supported institutions of higher education may participate in business incubators within the state. This exemption includes companies in which faculty or staff may have an ownership interest.

**University Intellectual Property.** State Law also provides that it is not a conflict of interest, or a breach of ethical standards for an institution of higher learning to contract with a person or firm in which an employee or former employee has a financial interest if such contract, subcontract or proposal involves patents, copyrights, or other proprietary information in which the institution and the employee have rights or interests.
There are restrictions on such activities: the contract or agreement must be approved by the University of Arkansas Board of Trustees in an open meeting.

**Blind Trusts.** Where an employee or any member of the employee's immediate family holds a financial interest in a blind trust, the employee shall not be deemed to have a conflict of interest with regard to matters pertaining to that financial interest if disclosure of the blind trust has been made to the Conflict of Interest Committee.

- **MANAGEMENT**

**Resolution of Conflicts of Commitment.**
Ordinarily, conflicts of commitment shall be resolved at the first level of review by the Responsible Administrator. Disclosure forms must be forwarded, with attachments indicating actions and resolution, to the appropriate Dean and subsequently to the office of the Vice Chancellor for Academic Affairs.

**Resolution of Conflicts of Interest.**
The Responsible Administrator in the primary review shall attempt to identify and resolve potential conflicts of interest and attach any recommendations to the disclosure form before forwarding. In cases of potential or actual conflicts of interest, one or more of the following steps shall be taken under guidance from the department chair, the appropriate Dean, the Vice Chancellor for Academic Affairs, and/or the Conflict of Interest Committee:

- Public disclosure of Significant Financial Interests.
- Monitoring of research by independent reviewers.
- Modification of the research plan.
- Withdrawal from participation in all or a portion of the research to which the conflict applies.
- Divestiture of Significant Financial Interests.
- Severance of relationships that create actual or potential conflicts.

In the event that there appears to be no satisfactory arrangement to manage a conflict of interest related to externally sponsored research or other activities, appropriate officials of the sponsoring entity shall be informed by the Vice Chancellor for Academic Affairs or his/her designee.

- **ADMINISTRATIVE ACTIONS, PENALTIES, AND APPEALS**

**Judgment.**
Legal penalties may be adjudged in cases of conflict of interest or commitment that violate state or local laws; any such penalties shall be determined by duly constituted judicial bodies. Non-judicial or administrative actions may result from a determination by the appropriate University official with the right of appeal to the UAMS Conflict of Interest Committee and the Chancellor.

**Notification of Federal Agencies.**
If the failure of the investigator to comply with this conflict of interest policy has biased the
design, conducting, or reporting of federally funded research, UAMS shall promptly notify the awarding agency of the corrective action taken or to be taken.

**Administrative Sanctions.**
Failure to disclose conflicts of interest in an appropriate and timely manner, or failure to comply with procedures to resolve conflicts of interest as recommended by the Conflict of Interest Committee shall result in administrative sanctions determined by the Vice Chancellor for Academic Affairs with advice from the appropriate Dean or other administrative officials and the Conflict of Interest Committee.

Additional administrative action may include oral admonishment, written reprimand, reassignment, disqualification from submitting proposals for research support to Federal Agencies or other sponsors, demotion, suspension, or separation.

**Appeal.**
Appeal of any determination by a Responsible Administrator may be made to the next higher level or to the Conflict of Interest Committee. Appeal of sanctions determined as above may be made to the Chancellor, whose decision shall be final.

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**Appendix 1**

Examples of Activities or Interests which Require Disclosure and may Require Special Procedures because of Potential Conflicts of Interest and/or Commitment

1. Any Significant Financial Interest (Definitions, 5.6), on the part of an academic staff member or his/her immediate family, that would reasonably appear to be affected by research for which external funding is sought or in entities whose financial interests would reasonably appear to be affected by the research.
2. The undertaking of basic or clinical research when the investigator (or the investigator's immediate family) has a Significant Financial Interest in the sponsoring entity or in the entity producing the product being evaluated or in a competing entity.
3. Gifts, favors, or gratuities from suppliers, research sponsors, organizations, corporations, or persons who have dealings with UAMS, if these gifts exceed a nominal value (see Appendix 3 for further discussion).
4. Side agreements to any contracts or business dealings between UAMS and suppliers, research sponsors, corporations, or other entities or persons.
5. Use of institutional supplies or equipment to support the research or other efforts of an independent company, agency, or institution in which the investigator has a Significant Financial Interest.
6. Use of the name of UAMS, The University of Arkansas, a college, a center or a department in a manner to produce personal financial benefit.
7. Accepting support for research under terms or conditions in which the information will not be published in a timely manner. (It is recognized that, for proprietary reasons, sponsoring agencies or commercial companies may delay publication for finite, but limited, periods; this is not considered a delay in timely publication.)
8. Negotiation of contracts between UAMS and companies in which the faculty member has a Significant Financial Interest.
9. Accepting external sponsorship for research or for a contract without processing through the normal administrative channels (ORA for UAMS, ORA and ACHRI for ACHRI, VA R&D Committee for VA).
10. A faculty member conducting research, professional practice, or educational activities externally that would ordinarily be conducted within UAMS or affiliated hospitals, in view of a primary commitment to UAMS.
11. A faculty member publishing research results of a clinical trial or other investigation in which the member has a Significant Financial Interest in those results.
12. Participation in UAMS committee or purchasing or contracting decisions that are related in any way to a business enterprise in which the faculty member has a Significant Financial Interest (see Definitions, 5.6).
13. Assumption of an executive position in a for-profit or not-for-profit institution or agency engaged in biomedical research.
14. Use of students or employees of UAMS to perform personal or commercial services unless these personnel are administratively separate and are compensated for work performed on off hours, and the work is not related in any way to their academic pursuits.

• Appendix 2

Activities That Are Normally Allowable and Need Not Be Disclosed

1. Salary, royalties, or other remuneration received from UAMS, including equity ownership.
2. Receipt of royalties for published scholarly works and other writings.
3. Acceptance of honoraria for papers, occasional lectures, and seminars as long as the honoraria are not excessive and are sponsored by public or non-profit entities.
4. Occasional income from service on advisory committees or review panels for public or nonprofit entities.
5. Significant interests in business enterprises or entities on the part of an investigator and the investigator's spouse and dependent children, which are not in any way related to the investigator's professional role and obligations.
6. Any "arms length" financial interests which occur through participation in mutual funds or employer's retirement plans.
7. Participation in clinical or other research sponsored by companies in which the faculty or staff member holds no financial interest or in which financial interest has been divested, provided the research has been reviewed by the appropriate administrative channels (ORA for UAMS, ORA and ACHRI for ACHRI, VA R&D Committee for VA).

• Appendix 3


Guidelines for Gifts from Industry to Academic Staff.

1. Any gifts accepted by academic staff individually should primarily entail a benefit to academic pursuits and should not be of substantial value. Accordingly, textbooks, modest
meals and other gifts are appropriate if they serve a genuine educational function. On the other hand, cash payments serve only the academic staff's personal interest and therefore should not be accepted from industry.

A gift which is appropriate because of its contribution to academic pursuits may become inappropriate because of its extravagance.

Gifts of minimal value raise fewer concerns and are permissible as long as the gifts are related to the staff member's work (e.g., pens, diaries, books or rulers).

2. Gifts by drug companies to underwrite medical conferences or other professional meetings enhance the ability of academic institutions, professional associations and health care organizations to provide continuing education to academic staff. Consequently, such gifts make an important contribution to academic pursuits. Subsidies from industry should not be accepted to pay for the costs of travel, lodging or other personal expenses of staff attending conferences or meetings, nor should subsidies be accepted to compensate for the staff's time. Subsidies for hospitality should not be accepted outside of modest meals or social events held as a part of a conference or meeting.

It is appropriate for faculty at conferences or meetings to accept reasonable honoraria and to accept reimbursement for reasonable travel, lodging and meal expenses. It is also appropriate for consultants who provide genuine services to receive reasonable compensation and to accept reimbursement for reasonable travel, lodging and meal expenses. Token consulting or advisory arrangements cannot be used to justify compensating academic staff for their time or their travel, lodging and other out-of-pocket expenses.

The giving of a gift directly to an academic staff member from a company's sales representative may create a personal relationship which would influence the use of the company's products. Accordingly, when a company contributes funds for conferences that are sponsored by academic or other educational institutions, the funds should be given by the company to the conference sponsor who in turn can use the money to reduce the conference registration fee. Payments to defray the costs of a conference should not be accepted directly from the company by the staff attending the conference.

3. No gifts should be accepted if there are prerequisites to their acceptance.

4. Sponsors of continuing medical education conferences have a special responsibility to ensure that gifts are appropriate. The Accreditation Council for Continuing Medical Education has adopted a number of useful guidelines to prevent industry funding for continuing medical education conferences from leading to undue influence by the companies: (a) responsibility for and control over the selection of content, faculty education methods and materials should belong to the accredited sponsors of conferences, (b) presentations must give a balanced view of all therapeutic options, and (c) financial support must be acknowledged in printed announcements and brochures, but reference should not be made to specific products.
The Task Force on Pharmaceutical Industry/CME Cooperation is currently developing an updated set of guidelines for industry funding of continuing medical education conferences.

Some of these guidelines are appropriate for smaller educational meetings and in other educational contexts, for example, when companies support meetings or lectures for medical trainees.

5. Financial support for conferences should be disclosed publicly. Staff will be able to evaluate the information presented to them more appropriately if they are aware that companies have contributed funds to defray the costs of the presentation.

- Appendix 4

UAMS Annual Disclosure of Outside Activities and Interest Form
POLICY GOVERNING SERVICE OF VOLUNTEER FACULTY

Definition

A volunteer faculty member is an individual who is appointed to an academic position on a full-time or part-time basis at no salary. There are two types of volunteer faculty: clinical faculty and adjunct faculty.

Clinical Faculty - Those appointed under this category will receive titles of Clinical Professor, Clinical Associate Professor, Clinical Assistant Professor and Clinical Instructor. Clinical faculty will be assigned to the clinical areas of the University of Arkansas for Medical Sciences or to any other campus of the University which has clinical programs in health care and psychology.

Adjunct Faculty - Volunteer faculty not associated with a clinical activity will receive titles of Adjunct Professor, Adjunct Associate Professor, Adjunct Assistant Professor, or Adjunct Instructor.

Appointments and Promotions

Appointments are recommended by Department Head or Chairman, Dean and Chancellor, and approved by the President for the Board of Trustees. Appointment notices shall state the contemplated performance period, but the relationship is one "at will" from which either party may withdraw at any time. Notice of withdrawal shall be by letter, but neither party shall be obligated to assign or announce reasons for withdrawing from the relationship.

Tenure Considerations

Volunteer faculty will not be granted tenure, and the time spent as a volunteer faculty member will not count toward tenure in event a volunteer faculty member is appointed to a salaried position.

Termination

The President, acting for the Board of Trustees, will approve all terminations.

Privileges

Volunteer faculty will have the following privileges and benefits:

1. Use of University libraries.
2. Option to purchase tickets to University activities as a faculty member of the campus sponsoring the activities.
3. Medical benefits under the Worker's Compensation law.
4. Parking privileges within campus regulations.
5. Service on University and student committees.
6. Use of facilities within University regulations.
7. Normal administrative support for courses taught.
8. Reimbursement for expenses such as travel directly applicable to courses taught.

November 3, 1978 (Revised)
January 17, 1977
RECOMMENDATION FOR TENURE

By Feb. 15 of each year the Chancellors and the Vice President and Provost will submit in writing to the Executive Vice President a positive recommendation for those faculty members who are eligible to receive tenure with the next two appointments and who will not be given "notice" of non-reappointment as provided above. This includes Professors and Associate Professors, and those who will be promoted to those ranks, who will receive the fourth appointment for the next year, and Assistant Professors and Instructors who will receive the seventh appointment for the next year. In the absence of a positive recommendation, it will be assumed that the individual will receive a written notice of non-reappointment, or a terminal appointment, in accordance with the above schedule. Copies of notice of non-reappointment are to be sent to the Executive Vice President.

This requires that Department Heads, Deans and other administrators examine annually the personnel files of non-tenured faculty to determine which members will be eligible for tenure with the next appointment (July 1 or beginning with fall semester) or appointment on similar dates the following year.

(See Board Policy for complete statement on tenure and non-reappointment.)

September 30, 1977
UNIVERSITYWIDE ADMINISTRATIVE MEMORANDUM

REVIEW OF PROMOTION AND TENURE CRITERIA

Board of Trustees' Policy 405.1 requires that criteria for promotion and tenure be developed by faculty on each campus and be reviewed and approved by various campus officials and the president.

Since conditions affecting promotion and tenure are subject to change, criteria for promotion and tenure, along with internal procedures to be followed, shall be reviewed through regular channels as required by Board Policy 405.1 and proposed revisions shall be forwarded to the Vice President for Academic Affairs. The first review is to be completed during the fall semester of 1987, or earlier if feasible, and additional reviews shall be made no less often than every four years thereafter. New criteria, if approved by the President, shall be the criteria used for promotion and tenure considerations for the following academic year and until further changes are made.

April 15, 1986
POLICY

The University of Arkansas for Medical Sciences will utilize its own employees where ever possible. In instances where a department determines that contracting for a function to be performed by a third-party company is practical and cost effective, a contract will be written and approved according to UAMS policies. Likewise, a department may appoint a non-employee to a Visiting Faculty Appointment.

Employees of another company or institution (“non-employee”) are not UAMS employees and do not fall under any aspect of employment law, regulations, or policies. However, non-employees need various campus privileges in order to function effectively; further, UAMS demands that non-employees follow basic UAMS policies, including the Code of Conduct. The department who supervises the contracting company will be the “sponsoring department” for all of the company’s employees who require campus privileges and ensure that these policies are followed.

PROCEDURES

1. Sponsoring departments will use the SAP transaction “Non-Employee Basic Data” enter into SAP basic demographic information on each non-employee, including name, Social Security number, employing company and its address, start and end dates of campus presence, work phone, work location, mail #. A form (page 3) to gather this information may be helpful.

2. Information on the non-employee database will be shared with UAMS Police, ID Badge system, Library, Clinical Information Systems, Telecommunications/Mailroom and others as applicable so that services can be provided – ID Badge, domain privileges, listing in the on-line telephone directory, and so forth.

3. UAMS departments will grant privileges according to general guidelines. Non-employees may be required to sign Confidentiality Agreement, parking rules, or other agreements normally signed by UAMS employees.

4. Non-employees may be required to attend UAMS New Employee Orientation, as applicable to employees in the Division where they are sponsored. They must adhere to the Employee Basic Code of Conduct, Inclement Weather policy, Employee Separation Procedure, and other policies as specified by the sponsoring department.

5. Non-employees may also be required to consent to Drug Testing and Criminal Background Testing. Sponsoring departments may obtain these from the contracted company or use UAMS facilities to accomplish. The sponsoring department must pay the cost of tests performed by UAMS facilities.
Sponsoring departments are responsible for entering non-employee information into SAP, using PA40, “Non Employee Basic Data”. This form may be used if helpful to the department. UAMS privileges will not be granted to any non-employee unless and until the non-employee is in SAP database.
For questions and assistance, please contact the Library Assistant Director (Jan Hart, Ed.D., 686-6751, hartjanicek@uams.edu). Questions requiring additional attention will be forward to designated UAMS counsel. UAMS faculty, students, and staff are directed to the University of Texas System Crash Course in Copyright http://www.utsystem.edu/ogc/intellectualproperty/cprtindx.htm for detail discussion of copyright issues.
The University of Arkansas for Medical Sciences is an accredited nonprofit educational institution supporting the activities of educators, scholars, researchers, and students. UAMS promotes an environment of compliance with copyright laws through the campus-wide distribution of the Guidelines for UAMS Faculty, Staff, and Students Using Copyrighted Materials throughout the Colleges and the educational support units.

UAMS promotes the educational and research use of copyrighted materials (Appendix A. Basic Copyright Law) through the appropriate application of the provisions provided in copyright law for fair use (Appendix B. Fair Use) and for specific exemptions granted for educational and research purposes (Appendix C. Exemptions). At this time, exemptions include the Teaching Exemption, the provisions for distance education covered by the Technology, Education, and Copyright Harmonization Act (TEACH Act), and special Library Exemptions. UAMS observes ‘best practices’ and ‘guidelines’ commonly accepted within the academic community (Appendix D. Guidelines).

The Institutional Responsibilities of UAMS (Appendix E) document addresses the institutional administrative and technological responsibilities required to take advantage of fair use and exemptions.

These institutional policies and guidelines were approved the UAMS Chancellor’s Cabinet, the UAMS Administrative Council, and Harold Evans, JD, of Williams and Anderson LLP.

Guidelines for UAMS Faculty, Staff, and Students Using Copyrighted Materials
Teaching in the Face-to-Face Classroom (Teaching Exemption)
Fair Use for Teaching Faculty and Students at UAMS
Distance Education and TEACH Act
Course Management Software (WebCT) and E-Reserves
Fair Use of Digital Images
Fair Use for Scholarship and Research

College of Medicine Guidelines for Use of Copyrighted Materials in Education
Brief guidelines designed to alert teaching faculty to copyright issues.
(Also adopted by the College of Nursing and College of Pharmacy)

Appendices: Summaries of copyright law and guidelines
Appendix A. Basic Copyright Law - 17 U.S. Code 102
Copyright from the code

Appendix B. Fair Use - 17 U.S. Code Section 107

Appendix C. Exemptions
Teaching Exemption - 17 U.S.Code 110(1)
Library Exemptions (17 U.S. Code 108)

Appendix D. Guidelines
Educational Fair Use Guidelines for Digital Images
http://www.utsystem.edu/ogc/intellectualproperty/copypol2.htm
Guidelines for Classroom Copying of Books and Periodicals
http://www.utsystem.edu/ogc/intellectualproperty/clasguid.htm

Appendix E. Institutional Responsibilities of UAMS

http://www.library.uams.edu/policy/copyright.aspx
PURPOSE

In accordance with Arkansas Act 271 of 1983, and Act 296 of 1995, the University of Arkansas for Medical Sciences is authorized to make available to eligible non-tenured faculty members and staff employees the opportunity to receive certain benefits in exchange for immediate retirement. Participation is strictly voluntary and is not mandated upon either eligible non-tenured faculty or staff or UAMS. Participation is not entitlement, but may be available to qualified non-tenured faculty members and staff employees when:

1. A savings to the University in salary and fringe benefits costs can be demonstrated,
2. The Board of Trustees of the University of Arkansas determines that the savings realized as a result of the agreement provide for a more efficient operation of the University, and
3. The terms and conditions of the retirement agreement would not be detrimental to UAMS and its’ programs. Determination of this factor would include, but not be limited to, such considerations as whether sufficient financial and staffing resources will be available to the department, campus, and unit from which the individual is retiring.

DEFINITION OF TERMS

1. Voluntary Early Retirement – A voluntary election on the part of an eligible employee who plans to retire from UAMS prior to "normal retirement age", in return for incentive financial consideration offered by the institution.
2. Voluntary election – A decision made by the employee based solely on their wish to elect the voluntary early retirement option, without coercion from any UAMS representative, and in accordance with the rules of the voluntary early retirement plan of the University of Arkansas and applicable laws.
3. Voluntary Early Retirement Agreement – A written document outlining the terms of voluntary early retirement for the employee and the employer.
4. Eligible employee - A UAMS employee (non-tenured faculty, classified or non-classified administrative staff) who meet eligibility requirements as established in this policy.
5. Retirement cost – The cost of all salary and benefits, including future part-time teaching, research, or other employment related costs of the eligible employee.
6. Replacement cost – The estimated salary and benefits cost of the individual(s) who will be employed to fill the position or responsibilities of the retiring eligible employee.
7. Retention cost – The last annual salary and benefits costs of the retiring eligible employee, including any increases in salary or benefits approved prior to the effective dates of the Voluntary Retirement Agreement.
8. Employee Waiver – A signed document in which the eligible employee has voluntarily signed which removes the institution’s obligation to provide 45 days to consider the terms of their participation in the Voluntary Early Retirement Program.
9. Statement of Assurance – A signed document in which the eligible employee states that they made the election to voluntarily elect early retirement, has been informed of their legal rights under the Age Discrimination in Employment Act, and has been advised and has had the opportunity to seek the advice and counsel of attorneys, accountants, and others who might assist in making an informed decision concerning the Program.
10. Early Retirement Program Worksheet - A spreadsheet which outlines the cost savings for the institution over a period not to exceed seven (7) years, by the participation of the eligible employee in the Voluntary Early Retirement Program.

11. Maximum dollar value of benefits – An amount received under the Voluntary Early Retirement Agreement which shall be established by the institution, and approved by the President of the University of Arkansas System, or such lesser amount as is necessary to show a cost savings to the institution within seven (7) years.

12. Post-early retirement wages – An annual payment for work performed which shall not exceed 30% of the eligible employee’s last full-time annualized salary.

**PROCEDURE**

1. The Chancellor of UAMS will determine, based on recommendation of the Vice Chancellor for Administration & Fiscal Affairs, appropriate time(s) during any fiscal year to offer an open window for election of voluntary early retirement by eligible employees.

2. A request from the Chancellor will be made to the President of the University of Arkansas System outlining the maximum benefit to be paid, and the proposed election window. The President may approve the request to initiate a voluntary early retirement election window.

3. Following approval by the President, the Office of Human Resources will prepare communication to eligible employees informing them of the option to elect voluntary early retirement.

4. During the election window, eligible employees meeting the applicable minimum qualifications for participation in the Voluntary Early Retirement Program may initiate a request for the institution to consider their participation in the program. The request must be submitted in writing by the eligible employee to their department head.

5. The employee’s department head is responsible for negotiating an agreement with the employee which meets the financial savings guidelines of the program, and is consistent with the incentive options outlined below. Incentive options not specifically listed below must be approved by the Office of Human Resources prior to signing the agreement. The Office of Human Resources is available as a resource for managers to assist in designing employee Voluntary Early Retirement agreements, but is not authorized to furnish legal, tax or other professional advice. In developing the Voluntary Early Retirement Agreement, the eligible employee must be apprised of their rights under the Age Discrimination in Employment Act and be advised to seek the advice of counsel of attorneys, accountants, and others who can provide information that will assist in making an informed decision. In all cases, the eligible employee must be given at least 45 days to consider the Voluntary Early Retirement Agreement and once signed, the employee has 7 days to revoke the signed agreement, unless waived in writing.

Financial incentives to be offered may include, but are not limited to:

- Stipend payment without requiring work

- Wages for part-time work (subject to the guidelines listed in definition, item 12 above)

- Contributions to a designated funding sponsor under the University of Arkansas Retirement Plan

- Reimbursements for major medical and/or life insurance premiums

- Other arrangement as agreed by the employee and the employer

The Chancellor will determine the maximum stipend amount for each election window. However, the total stipend amount paid to an eligible employee under an agreement may not normally exceed 50% of the employee’s final salary with UAMS.

1. Department heads must review each voluntary retirement agreement with their division head for approval.

2. The Office of Human Resources will serve as a collection point for signed Voluntary Early Retirement Agreements, which have been signed by the eligible employee and their department/division head.

3. The Office of Human Resources will prepare a report outlying each of the Voluntary Early Retirement

http://uams.edu/AdminGuide/Win04116.html
Agreements for the Vice Chancellor for Administration & Fiscal Affairs at the end of the election window. The Vice Chancellor will recommend the Voluntary Early Retirement Agreements, which meet UAMS’ needs to the Chancellor.

4. The Chancellor shall recommend approval to the President, who shall review each Voluntary Early Retirement Agreement with the Board of Trustees of the University of Arkansas or final approval.

5. The Office of Human Resources shall execute the terms of the agreement, once approved by the Board of Trustees.

**REQUIREMENTS**

Before a Voluntary Early Retirement Agreement can be approved, savings in salary and fringe benefits costs to the Medical Center must be demonstrated. The cost savings must be realized within seven years of the effective date of retirement. A cost savings will be determined for each year of the seven-year period by subtracting the retirement cost and replacement cost from the retention cost. The fact that a cost savings is not shown in one year will not prevent an employee from qualifying for a Voluntary Early Retirement Agreement if a total cost savings can be realized over the seven-year period. For purposes of this determination,

"Retirement cost" means the costs of all salary and benefits, including future part-time teaching, research, or other employment related costs of the eligible, including the University’s portion of FICA taxes;

"Replacement cost" means the estimated salary and fringe benefits cost of the individual or individuals who will be employed to fill the position or responsibilities of the retiring eligible employee;

"Retention cost" means that the last annual salary and fringe benefits cost of the retiring non-tenured faculty member or staff employee, including any increases in salary or fringe benefits approved prior to the effective date of the Voluntary Early Retirement Agreement.

The maximum dollar value of benefits that can be received under a Voluntary Early Retirement Agreement is the annual salary of the retiring employee for the current fiscal year or such lesser amount as is necessary to show a cost savings to the University within seven years.

**FUNDING OF VOLUNTARY EARLY RETIREMENT AGREEMENTS**

All cost associated with a Voluntary Early Retirement Agreement, including stipends, FICA on stipends, wages, FICA on wages, contributions to retirement accounts, reimbursement of major medical and/or life insurance premiums, and any other costs will be the sole responsibility of the department.

**TIME OF AVAILABILITY**

Proposals for Voluntary Early Retirement of qualified non-tenured faculty members and staff employees of UAMS will be considered during announced periods of time or windows of opportunity, with retirement to take place at the convenience of the employing department or other unit, but no later than the end of the current fiscal year. Subject to the approval of the Chancellor, UAMS may consider proposals for voluntary early retirement during as many or as few time periods or windows of opportunity as it determines are in its best interests to offer. A window of opportunity may be opened to non-tenured faculty only, to staff only, or to both. There is no requirement that any such opportunities be offered at a later date nor that they will be offered on a regular basis. The University also reserves the right to modify the number of years of continuous employment required for eligibility and the form of benefits available during any given window of opportunity, subject to approval by the Chancellor and in accordance with applicable policies. A request for early retirement must be in writing and must be received by the head of the department and the appropriate supervisor within the window incentive period to be considered under this policy.

**ELIGIBILITY**
Proposals for voluntary early retirement will be received only from eligible employees who are at least 55 years of age and who have been continuously employed 50% or greater for at least 15 years on the effective date of their retirement. Eligible employees may not currently be on leave without pay or receiving either long-term disability insurance benefits or worker’s compensation benefits.

Eligible employees who have had no more than three years in a leave-without-pay status are not prevented from entering into an early retirement agreement as long as they can otherwise show 15 years of full-time employment. Years of employment will be calculated in whole year increments. In the case of an individual on a 12 month appointment, fractions of years of employment that are 6 months or less will be rounded down to the next lowest full year. Fractions of years of employment that are greater than 6 months will be rounded up to the next highest year. In the case of an individual on a 9 or 10-month appointment, years of employment will be calculated with the fall and spring semester each representing half a year. Time spent in an "off-campus duty assignment" will be counted in computing continuous employment.

VOLUNTARY EARLY RETIREMENT AGREEMENT

And

STATEMENT OF ASSURANCE

This agreement is entered into by and between , a non-tenured faculty member or staff employee of the University of Arkansas for Medical Sciences, and the Board of Trustees of the University, on this the day of , 19__.

That he or she has been an employee of the University since and currently holds the title of .

That he or she is not on leave-without-pay status, receiving long-term disability insurance benefits, or receiving workers’ compensation benefits;

That on his or her own initiative, he or she has sought an agreement for early retirement, pursuant to Arkansas Code Annotated §24-7-102 and University wide Administrative Memorandum 430.0;

That he or she has been apprised of his/her rights under the Age Discrimination in Employment Act as amended;

That he or she has been advised and has had the opportunity to seek the advice and counsel of attorneys, accountants, and others who could aid her/him in making an informed decision regarding the Voluntary Agreement;

That he or she has been given at least 45 days to consider his or her voluntary early retirement; and

That he or she does hereby voluntarily resign his/her position as effective , recognizing that his/her employment with the University of Arkansas for Medical Sciences will then end.

The Board of Trustees of the University of Arkansas for Medical Sciences hereby accepts such voluntary resignation and agrees to provide:

1) 

2) 

3)
This agreement shall be binding on the employee described above and on his/her heirs, estate, and personal representatives, and on the Board of Trustees and its successors; provided, however, that (1) any agreement to pay for part-time services shall terminate for all unaccrued and unearned amounts on the death of the employee described, and (2) all other rights and/or obligations to or for the benefit of the faculty member or staff employee shall terminate at her/his death.

All earlier oral or written agreements regarding employment, between the Board of Trustees of the University and/or the University of Arkansas and are superseded by this agreement. This agreement does not affect or alter the rights, privileges, or options accrued to this date which now has under pension (annuity), insurance, or other plans (if any) in which has participated and to which the University has made contributions, nor any rights, privileges, or options to which retired faculty members or staff employees are entitled because of that status or eligible thereto.

Witness:

Employee

Witness: Board of Trustees of the University of Arkansas for Medical Sciences

EARLY RETIREMENT PROGRAM

WAIVER OF 45 DAY CONSIDERATION

I, , hereby waive the 45 day period for consideration of the terms of and my participation in the voluntary early retirement program for the University of Arkansas for Medical Sciences. I further state that:

I have voluntarily sought this agreement on my own initiative;

I have been apprised of my rights under the Age Discrimination in Employment Act; and I have been advised and have had the opportunity to seek the advice and counsel of attorneys, accountants, and others who could aid me in making an informed decision regarding the terms of my early retirement agreement.

Employee Date

EARLY RETIREMENT PROGRAM

STATEMENT OF ASSURANCE

By my signature below, I, , do hereby assure the members of the Board of Trustees of the University of Arkansas that I have voluntarily sought participation in the University of Arkansas’ Voluntary Early Retirement Program for Staff and Non-Tenured Faculty; that I have been apprised of my rights under the Age Discrimination in Employment Act; and that I have been advised and have had the opportunity to seek the advice and counsel of attorneys, accountants and others who might assist me in making an informed decision concerning the Program.

Employee Date
UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES
EARLY RETIREMENT PROGRAM
WORKSHEET

NAME:

POSITION & DEPARTMENT:

DATE OF RETIREMENT:

BIRTHDATE:

YEARS ON APPOINTMENT:

AGE AT RETIREMENT:

CURRENT APPOINTMENT PERIOD (9 OR 12 months)

SALARY – CURRENT YEAR:

<table>
<thead>
<tr>
<th>COSTS AND SAVINGS</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
<th>Year 6</th>
<th>Year 7</th>
<th>Totals</th>
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<tbody>
<tr>
<td>Retention Cost:</td>
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<td>Salary</td>
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<td>Benefits</td>
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http://uams.edu/AdminGuide/Win04116.html

11/1/2005
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<tr>
<th>Total Cost</th>
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**Retirement Cost:**

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<th>Salary</th>
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<th>Other</th>
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**Total Cost**

<table>
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<th>Replacement Cost:</th>
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<table>
<thead>
<tr>
<th>Benefits</th>
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</table>

**Total Cost**

**COST SAVINGS**
Faculty Resources

3. UAMS Leave Policies

- Annual Leave/Vacation (Admin Policy 4.6.04)
- Attendance at Professional Meetings
- Catastrophic Leave (Admin Policy 4.6.07)
- Court and Jury Duty Leave (Admin Policy 4.6.06)
- Educational Leave (Admin Policy 4.6.10)
- Family Medical Leave (Admin Policy 4.6.11)
- Holidays (Admin Policy 4.6.02)
- Inclement Weather (Admin Policy 3.1.02)
- Leave of Absence Without Pay (Admin Policy 4.6.08)
- Military Leave (Admin Policy 4.6.05)
- Off Campus Duty Assignments (Admin Memorandum 435.4)
- Sick Leave (Admin Policy 4.6.03)
- Voting Time (Admin Policy 4.06.09)

A complete listing of leave policies in the UAMS Administrative Guide may be found at http://uams.edu/AdminGuide/index.html#4.6

Back

10/06/2005
The State of Arkansas and the University of Arkansas for Medical Sciences (UAMS), in conformance with the
Arkansas Code Annotated 21-4-201 and OPM policy 105.2 and the University of Arkansas Board of Trustees Policy
Statement 420.1 and 420.2, have established uniform procedures under which annual leave (vacation) may be granted
and taken. The purpose of this policy is to inform all departments within UAMS of these procedures so that uniformity
can be established throughout the campus.

PROCEDURE

(1) All regular, probationary, provisional, and part-time employees who work 20 hours or more per week shall accrue annual leave. Annual leave must be earned before it can be authorized, and may not be borrowed from future credits or advanced beyond actual accrual, regardless of length of service.

(2) Full-time Classified and Non-Classified Patient Care employees shall accrue annual leave in accordance with the following schedule:

<table>
<thead>
<tr>
<th>Length of Employment</th>
<th>Monthly Accrual</th>
<th>Annual Accrual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Through 3 years</td>
<td>1 day</td>
<td>12 days</td>
</tr>
<tr>
<td>3 to 5 years</td>
<td>1 day, 2 hours</td>
<td>15 days</td>
</tr>
<tr>
<td>5 to 12 years</td>
<td>1 day, 4 hours</td>
<td>18 days</td>
</tr>
<tr>
<td>12 to 20 years</td>
<td>1 day, 6 hours</td>
<td>21 days</td>
</tr>
<tr>
<td>Over 20 years</td>
<td>1 day, 7 hours</td>
<td>22 days, 4 hours</td>
</tr>
</tbody>
</table>

(3) All Non-Classified Administrative and Faculty employees shall accrue annual leave at the rate of 22.5 days per calendar year (1 Day, 7 Hours per Month), regardless of length of service. Faculty on 9 or 10 Month contracts who abide by the student time-off schedule shall not accrue annual leave. Employees who work less than full-time, but more than 20 hours per week, shall accrue annual leave in the same proportion to the time worked.

(4) Annual leave is cumulative; however, no employee may have accrued annual leave in excess of 30 days on December 31 of each year. Accrued annual leave may exceed 30 days during the calendar year, but days accrued in excess of 30 will be lost if they are not used before December 31 of each year.

(5) Annual leave may not be accrued during a period of leave without pay when such leave is for ten or more days within a calendar month.

(6) Employees may request the use of accrued annual leave at any time. Department directors and other appropriate department heads shall grant requests for annual leave when it will least interfere with the efficient operation of the department. Department directors/heads may, at their discretion, deny the use of annual leave to absent employees who have exhausted all sick leave if abuse of sick leave is suspected.

(7) Annual leave shall be granted on a basis of work days rather than calendar days, and shall be deducted from the employee's accrued leave in increments of not less than 15 minutes. Non-work days such as weekends and holidays falling within a period of annual leave will not be charged as annual leave.

(8) Upon termination, resignation, death or other action by which an active employee leaves the employment of the University,
the amount due the employee or their estate from accrued annual leave or holiday leave shall be included in the final pay to the employee. Unused annual leave to an employee's credit as of the last day of duty shall be liquidated by a lump sum payment not to exceed 30 working days, inclusive of holidays. No employee receiving such additional compensation shall return to University employment until the number of days for which he/she received additional compensation has expired. Employees transferring to another State agency or institution may transfer all accrued annual leave.
Attendance at Professional Meetings

Members of the teaching, research, administrative, and extension staffs are encouraged to attend professional meetings, as such attendance is deemed beneficial to both the individual and to the University. Brief leaves from official duties will be granted for attendance at such meetings when circumstances permit, the University will reimburse the individual for a part of the travel expenses when travel funds are available for such purposes and to the extent allowed by University travel regulations. Applications for leave and travel allowance for attendance at professional meetings must be approved in advance by the appropriate administrative personnel.
PURPOSE

The University of Arkansas for Medical Sciences (UAMS), in compliance with Act 169 of 1991[i], Act 1176 of 1999[ii], and the implementation "Rules and Regulations of the Office of Personnel Management[iii]" for that Act, has established a uniform procedure to administer an approved "Catastrophic Leave Bank Program". This program will allow UAMS employees to donate sick and/or annual leave for the purpose of assisting other employees, both Classified and Non-Classified, who have exhausted their time-off due to catastrophic accident or illness. Catastrophic Leave with pay (hereafter "Leave") is a type of "leave of absence" created when time-off hours (sick and annual leave) are donated to the UAMS Leave Bank for purposes of paying an employee when they are incapacitated and unable to perform the duties of their job due to a catastrophic illness or accident.

POLICY

It is the policy of UAMS that no employee shall directly or indirectly intimidate, threaten, or coerce (or attempt to do so) any other employee for the purpose of interfering with an employee's ability to donate, receive or use annual or sick leave, including Catastrophic Leave. Eligible leave donors shall be full-time, regularly appointed employees (Classified or Non-Classified) who have accumulated combined sick and annual leave in excess of 80 hours. For purposes of this policy, “full-time” shall be defined as 40 hours per week; 36 hours per week for 12-hour nurses and 24 hours per week for Week-end Option nurses and others who are declared “full-time for benefits” under specific compensation plans. Leave may be donated in increments of one hour or more. Once donated, the leave will not be restored to the leave donor under any circumstances. All donated leave becomes the property of the Leave Bank and may be used for the benefit of an eligible employee specified by the Catastrophic Leave Committee for any employee who meets the criteria for receipt of leave.

“Catastrophic illness’ means a qualifying medical condition of an employee, the spouse or parent of the employee, or of a child of the employee which may be claimed as a dependent under the Arkansas Income Tax Act of 1929 (Section 3. Arkansas Code 6-63-601(1)).

LEAVE ELIGIBILITY CRITERIA

Eligible leave recipients shall meet e) of the following requirements:

a) Occupation of a regular (non-temporary), non-faculty or non-resident, “full-time” benefits-eligible position for a minimum of two (2) years cumulative. “Full-time” is the same as defined above for leave donor, and service need not be continuous.

b) Exhaustion of all accrued annual, sick, holiday, and compensatory time-off, whereby continued absence will cause a substantial loss of income.

c) No disciplinary notices (written warning) for any leave abuse (absenteeism or related) during the past two (2) years.

d) Certification from a physician (or other individual as provided by law) of a Catastrophic Leave will be granted only as long as the physician certifies that the recipient is unable to work. Leave may not be awarded retroactively.

A "prolonged period" means a continuous period of at least thirty (30) working days or six (6) weeks wherein the employee cannot perform work duties. Routine disabilities or disabilities resulting from elective surgery do not qualify as catastrophic.

CONDITIONS OF PARTICIPATION

The leave recipient shall agree, as a voluntary condition of participation, that any sick, annual, or holiday hours accrued while receiving Leave from the program will be assigned to the Leave Bank upon their return to full duty.

The leave recipient shall agree that any unused portion of the Leave, such as created by separation from employment or return to work prior to...
While on Leave, the leave recipient shall be paid the normal base rate of pay and will continue to receive normal UAMS benefits, including UAMS contributions to insurance and retirement. The recipient's merit eligibility date will not change. The granting of Catastrophic Leave does not create any expectation or promise of continued employment.

Receipt of Catastrophic Leave shall be limited to the start of Long Term Disability (LTD) payments, or a maximum of six (6) months, unless the recipient can demonstrate that disability (Long Term Disability) or Social Security benefits have been denied.

Catastrophic Leave may be requested and granted in separate instances without regard for cumulative Leave granted.

**GRANTING OF LEAVE**

The Catastrophic Leave Policy Committee (hereafter "Committee") will review applications from employees for Leave. The Committee’s decisions are not subject to grievance, arbitration or litigation. Committee action may be appealed only to the Assistant Vice Chancellor of Human Resources.

The Committee shall be comprised of at least five members and the committee shall elect a chairperson from the committee membership. The Committee will be composed of a representative from the House of Delegates, the Academic Senate, the Office of Human Resources management, the Employee Assistance Program (EAP) and the Director of Human Relations. The Committee will review all requests for Leave, determine eligibility, and provide a process for dispute resolution on Leave issues, and will recommend action to the Chancellor or his designee. The Committee may grant Leave only in one (1) hour increments but may not approve Leave in an amount which would result in a negative balance in the UAMS Leave Bank. When the amount of Leave in the Bank is at or near exhaustion, applications will be reviewed on a first filed/first considered basis.

**PROCEDURE**

1. A leave donor may voluntarily donate sick and/or annual leave, reducing accrued leave to a minimum combined balance of 80 hours, by completing a form for this purpose. This form should be forwarded to the donor's timekeeper, for verification of the donor's leave balance. Following verification of the donor's eligibility, the timekeeper will forward the form to the Office of Human Resources (OHR). The donor cannot assign his/her hours to a particular employee.

2. Payroll will deduct the leave from the donor's accrued balance(s), OHR will notify the donor of the accepted reduction, and increase the Leave Bank accounts appropriately. The name of the leave donor, amount of leave donated, the rate of pay and the dollar value of the donated leave shall be recorded. No deduction made from department’s budget for the value of the leave donated.

3. An employee requesting hours from the Leave Bank may apply for Catastrophic Leave by completing a “Recipient Application Form” and sending it to their immediate supervisor or department head, stating a case for eligibility and need. A fellow employee, the supervisor, or the department head may also initiate the request. The appropriate forms can be printed from the UAMS website, [http://www.uams.edu/ohr/Forms.htm](http://www.uams.edu/ohr/Forms.htm). The required forms for an employee include the Recipient Application Form, Physician’s Certification Form and the Liability Agreement Form. For an employee to request Catastrophic Leave to provide care for a child, an additional Dependent Child Certification must be submitted and signed by the DFA-Revenue-Individual Income Tax Section. If the child is a newborn, then a copy of the birth certificate will be required. If the employee is requesting Catastrophic Leave to provide care for a parent, spouse or child a letter must be submitted from the physician and from the employee stating why constant care is needed from the employee.

4. The department head may support the employee's request by indicating on the application form that the employee meets each of the criteria for receipt of Leave. The department head may choose not to support the employee's request by indicating which of the criteria the employee fails to meet or any other reason the employee should not be granted Catastrophic Leave. In either case, the department head will forward the employee's request and the department's opinion to OHR. The requesting party (employee, colleague, or department representative) must ensure that a "Physician's Statement Form" is completed by the employee's attending physician and forwarded to OHR.

5. Upon receipt of the application form, OHR will verify that the employee meets all applicable criteria, that the department has issued an opinion, and that all forms and a physician's statement has been have been received. This information will be forwarded to the Chair of the Leave Policy the Catastrophic Leave Committee.

6. The Chair of the Leave Policy Committee will notify all Committee members that a request has been received and will open the case for review. The Committee will meet approximately every two (2) weeks to review applications and make the appropriate decisions based on the information provided.

7. When the employee's department is opposed to the granting of the Leave, the Committee will allow that department head and the requesting employee (or their spokesperson) to appear in person provide a written statement before the Committee.
8. If the Committee finds that the Leave should not be granted for whatever reason, the Committee will notify the employee in writing and allow the employee (or their spokesperson) to appear before the Committee and appeal the decision to the Assistant Vice Chancellor of Human Resources, in writing with additional supporting documents.

9. When approved, OHR will notify the employee’s department to post hours to “CATLV” for AccuTime electric posting, maximum hours, start date and stop date will be specified. Although paid, the employee will be considered on “Leave of Absence.” Thus the department should place the employee on Leave of Absence with Pay by processing this action in SAP using the PA40 transaction. For instruction on how to run this transaction, refer to the SAP on-line Training Manual, http://intranet.uams.edu/enterprise/Manuals.htm. As with other types of Leave of Absence (see Section 4.6 of the UAMS Administrative Guide), the department remains primarily responsible for returning the leave recipient to a same or similar position at the conclusion of the Leave of Absence. Department is responsible for funding the employee’s catastrophic leave.

10. The first twelve weeks of Catastrophic Leave will be counted toward the employee’s rights to leave under the Family Medical Leave Act of 1993 (FMLA). The notification to the employee will be included on the award letter that will be sent to the employee’s permanent address.

11. Any sick and annual leave or holiday leave accrued by the leave recipient will be reduced to zero and assigned to the Leave Bank upon the employee’s return to full duty. The department should not process sick and vacation time that will accrue once the employee’s vacation and sick amounts have been used and the Catastrophic Leave posting has begun.

12. When the approved Leave is exhausted at 1040 hours, or at the conclusion of six months, or when the recipient no longer requires Catastrophic Leave, the department shall cease to post hours and will notify the Committee OHR of the date of the employees returns or the last date of posting.

13. At the end of the Leave period, and where appropriate, OHR the department will initiate action to return the leave recipient to the same or similar position. A Return From LOA action need to be completed by using the PA40 transaction in SAP. For instruction on how to run this transaction, refer to the SAP on-line Training Manual, http://intranet.uams.edu/enterprise/Manuals.htm.

14. The Catastrophic Leave Bank will be administered in accordance with the following guidelines: The following records will be kept:

   a) For the donation process: the amount of leave donated by each employee, the rate of pay and dollar value of such donated leave at the time of donation;

   b) For the award process: the amount of Catastrophic Leave awarded, including the name of the recipient, position number, rate of pay and social security number; and

   c) Any other such data as required by the Director of the Department of Finance and Administration or UAMS.

**FORMS**

UAMS Catastrophic Leave Bank Program Recipient Application Form

UAMS Catastrophic Leave Bank Program Physician Statement Form

UAMS Catastrophic Leave Bank Program Liability Agreement

UAMS Catastrophic Leave Bank Program Dependent Child Certification

**REFERENCE**

[i] Act 169 of 1991

[ii] Act 1176 of 1999

PURPOSE

The University of Arkansas for Medical Sciences (UAMS), in conformance with Act 835 of 2003, Arkansas Code, Annotated § 21-4-213 & 21-5-104 and the Office of Personnel Management Policy 105.9.1, has established clearly defined uniform procedures under which court and jury leave may be granted and taken. The purpose of this policy is to inform all departments within UAMS of these procedures so that uniformity and equity can be established throughout the campus.

PROCEDURE

1. A UAMS employee who serves as a juror or is subpoenaed as a witness to give a deposition in a court or hearing, not involving personal litigation or service as a paid witness outside the scope of state employment is entitled to receive normal and full compensation in addition to any fees paid for such services. Such absences shall not be counted as annual leave. Employees normally scheduled for evening and night shift duty shall also be entitled to time-off from these shifts for court duty performed during the day.

2. Employees involved in personal litigation will be required to take annual leave.

3. It is the preference of the University that witnesses complete such service by providing a statement or deposition to the involved attorney whenever possible. Statements or depositions which involve the University may be taken during duty hours. All others should be handled during non-working hours.

4. Employees accepted by the court as expert witnesses and paid a fee in excess of the normal witness fee shall take annual leave for the time required for such testimony. Likewise, volunteers who have not been subpoenaed to serve as witnesses or those that are subpoenaed as a witness for personal litigation will be required to request annual leave.

5. If an employee’s service on a jury would substantially interfere with the execution of the University work schedule, then the appropriate Dean, Executive Director or Vice Chancellor may petition the judge in writing for exemption of the employee from service. However, if exemption is denied or if no response is received prior to the set date of jury duty, then the employee must report for jury duty.
PURPOSE

The purpose of this policy is to inform all departments within UAMS of these procedures so that uniformity can be established throughout the campus.

PROCEDURE

1) An employee of UAMS requesting educational leave must obtain approval from the University of Arkansas President. Employees requesting such leave must first submit the request in writing to the appropriate director or academic head of their department. Upon departmental approval, the request shall be forwarded to the appropriate division Dean, Executive Director or Vice Chancellor for division-level approval, and the division administrator shall then submit the approved request to the UAMS Chancellor for campus approval prior to forwarding it to the University President. Leave policies are different for Classified and Non-Classified patient care (see (2) below) and for Academic and Other Non-Classified Personnel (see (3) below).

2) Classified and Non-Classified Patient Care: A permanent employee may be granted educational leave by the President of the University on the following basis:

   1. The employee will continue in the service of the University for a period of time as statutorily required or in the absence of a specific law, at least twice the length of his or her course of training. Any employee who does not fulfill these obligations shall be required to pay to the University the total cost or a proportionate share of the cost of the out-service training and compensation paid during the training period.

   2. A written contract setting forth all terms of the agreement shall be signed by the employee and the President or Chancellor. The employee shall retain all rights in the position held at the time when the leave was granted or in one of comparable security and pay.

   3. The amount of salary paid during the training period will be agreed upon by the employee and the President or Chancellor but may not in any case exceed the regular salary paid the employee. Payments for tuition, fees, books, and transportation may be made only if such sums have been specifically appropriated by the General Assembly for such purposes.

3) Academic and Other Non-Classified Personnel:

   1. Leave-of-Absence Without Pay: The President of the University is authorized to grant leaves-of-absence without pay for a period not to exceed one year.
2. Vacation Leave for Graduate Study: Vacation leave for graduate study may be granted to otherwise eligible employees under the following terms:

   a) Accrued vacation with pay may, if used for graduate study, be accumulated for two calendar years preceding the date of the leave if it is used by January 1 of the third year.

   b) Permission to carry over such credit must be requested in writing by the employee and approved by the President in advance of the commencement of vacation accrual. The President may approve a modified application of the regulation where circumstances warrant not to exceed the earned vacation allowance for two years.
PURPOSE

UAMS recognizes the importance of achieving a healthy balance between work and family responsibilities. The Family and Medical Leave Act of 1993 (“FMLA”) requires certain employers to allow eligible employees to take up to 12 weeks of leave (paid and/or unpaid) to care for a newborn or newly adopted child, to recuperate from their own serious illness, or to care for a seriously ill family member. An eligible employee is one who has at least 12 months of employment with the State of Arkansas and has worked at least 1,250 hours during the previous 12-month period. The purpose of this policy is to notify employees and departmental supervisors within UAMS of the guidelines established by the FMLA and to ensure that uniform procedures and compliance exist across all organizational lines.

POLICY

An eligible employee may take up to 12 weeks of family and medical leave during a “rolling backward” 12-month period for specified family and medical reasons. Eligible employees are entitled to 12 workweeks of FMLA leave during any 12-month period. Under the rolling backward method, the 12-month period will be measured backward from the date an employee requests FMLA leave to determine whether the employee is eligible for any additional leave.

Family and medical leave may be requested for:

- **Birth, adoption, or foster care** --- A new parent or foster parent may apply for leave within one year after the child is born or placed in the parent’s home. If both parents work for UAMS, they will be entitled to a total of 12 weeks between them.

- **The employee’s serious health condition, as defined by law** --- This includes an employee who requires inpatient treatment, has a chronic health problem, is incapacitated for more than three calendar days while receiving medical treatment, or has a non-chronic health condition that could result in a period of incapacity for more than three calendar days without medical treatment or is pregnant (including prenatal care).

- A serious health condition, as defined by law, of an employee’s spouse, child, or parent and for whom the employee is needed to provide care.

1. Leave can be taken on a continuous, reduced, or intermittent basis depending upon the situation. A reduced leave schedule is one which reduces an employee’s usual number of working hours per workweek or hours per workday. Intermittent leave is taken in separate blocks of time due to a single qualifying reason. Employees should contact their immediate supervisor to request reduced or intermittent leave. *(Additional information on reduced and intermittent leave appears at the end of this administrative guide policy.)*

2. UAMS requires employees to use all unused sick days, annual/vacation days, and personal holidays during any FMLA leave. If an employee has exhausted all paid leave, the balance of the FMLA leave is unpaid. *(Exception: The State of Arkansas, OPM Section 105.5.1, provides that an employee taking maternity leave may elect to take a leave of absence without pay and not exhaust their accumulated annual and sick leave.)* At the point when an employee's FMLA leave is without pay, the department MUST place the employee on a FMLA "leave of absence without pay status" in SAP.
2. UAMS requires employees to use all unused sick days, annual/vacation days, and personal holidays during any FMLA leave. If an employee has exhausted all paid leave, the balance of the FMLA leave is unpaid. *(Exception: The State of Arkansas, OPM Section 105.5.1, provides that an employee taking maternity leave may elect to take a leave of absence without pay and not exhaust their accumulated annual and sick leave.*) At the point when an employee's FMLA leave is without pay, the department MUST place the employee on a FMLA "leave of absence without pay status" in SAP.

3. FMLA leave runs concurrently with any paid or unpaid leave that is taken (e.g., Worker’s Compensation and Catastrophic Leave). Any leave falling under the protection of FMLA cannot be classified as an occurrence in any absence control policy or practice, nor may any disciplinary action be taken for absences covered by FMLA. The department is responsible for making sure the employee’s job duties are fulfilled while the employee is on FMLA leave.

4. An employee will not accrue sick days, vacation days, or personal holidays while on an unpaid FMLA leave. While on unpaid intermittent or reduced-schedule FMLA leave, an employee’s accrual of sick, vacation, and personal days will be pro-rated in accordance with the intermittent or reduced work schedule. When FMLA leave is unpaid, the Office of Human Resources (OHR) will contact the employee to arrange for payment of their insurance premiums.

5. When FMLA leave is paid leave, the employee may maintain regular payroll deductions for benefit coverage, and UAMS will continue to pay the University share. The employee will also accrue vacation, sick, and holiday hours as long as they are on paid leave. If, at any time, the employee’s normal scheduled work hours are reduced and they are still in a pay status, their department is responsible for contacting Payroll to adjust their monthly leave accrual.

6. FMLA leave does not have to be requested by the employee. UAMS may designate the leave as FMLA when the guidelines for receiving leave are met. An employee’s department should notify the employee in writing that their leave will be classified as FMLA.

7. Upon return from FMLA leave, the employee is entitled to be returned to the same position held when FMLA leave commenced or to an equivalent position with equivalent benefits, pay, and other terms and conditions of employment. In the event that an employee’s position is eliminated as part of a scheduled reduction in force while the employee is on leave, UAMS is not obligated to reinstate the employee unless there is an open equivalent position available at the time the employee is able to return to work and for which the employee is otherwise qualified.

8. Certain “key employees” (as defined by law is a salaried FMLA-eligible employee who is among the highest paid 10 percent of all employees employed by UAMS) may be denied restoration to their jobs when that restoration would cause substantial and/or grievous economic injury to the University’s operations. An employee who is considered a key employee under the FMLA will be notified of that fact at the time he/she requests a leave of absence.

9. If an employee fails to return to work following FMLA leave, the employee may be required to reimburse UAMS for its share of benefit premiums paid on the employee’s behalf during the period of unpaid FMLA leave. If it becomes known that the employee is not returning to work and, therefore, ceases to be entitled to FMLA leave, the University’s obligation to provide health benefits (except as provided under COBRA) and to restore the employee to work will cease at that time. In order to be eligible for COBRA, the employee must first pay all of their portion of benefit premiums.

10. When an employee completes twelve (12) weeks FMLA leave in any twelve (12) month period and has not returned to work, the supervisor should contact the Employee Relations Manager in the Office of Human Resources for guidance.

11. Each department at UAMS is responsible for all documentation and record keeping and must maintain a record of all leave reports involving FMLA for a minimum of three years. This confidential file must be kept separate from other files and only include medical documents.

**PROCEDURES**

**Employee Notice:** An employee should request FMLA leave to the employee’s supervisor verbally or by submitting a written request for leave sufficient to make the employer aware that the employee needs FMLA qualifying leave and the anticipated timing and duration of the leave. An employee must provide the supervisor at least 30 days advance notice before FMLA leave is to begin if the need for leave is foreseeable based on an expected birth, placement for adoption or foster care, or planned medical treatment for a serious health condition of the employee or of a family member. If 30 days notice is not practicable, such as because of lack of knowledge of approximately when leave will be required to begin, a change of circumstances, or a medical emergency, notice must be given as soon as practicable.

- If the employee fails to properly inform the employer, he or she has no FMLA protection for the absence;
- For extended FMLA leave, the employee is required to give advance notice where possible, keep the supervisor informed of their need for continued leave, give two days notice prior to returning to work, and promptly return to work when the conditions which necessitated the leave are no longer present.

**Departmental Response:** If an employee requests FMLA leave or the employer designates time off as FMLA leave, the employer must provide the employee with written notice that includes, as appropriate, the following information:

- That the leave will be counted against the employee’s annual FMLA leave entitlement;
- Any requirement for a medical certification and the consequences of failing to provide certification;
- That the leave runs concurrently with any paid or unpaid leave that is taken;
- Any requirement to make premium payments to maintain health benefits, the arrangements for payments, and the consequences of failing to do so — the employee must contact OHR for assistance;
- Any requirement for a fitness-for-duty certificate and be restored to employment;
- The employee’s status as a “key employee” and its consequences;
- The right to restoration to the same or equivalent position; and
- Potential liability for the employer’s share of health insurance premiums paid by the employer if the employee fails to return to work.

If possible, the supervisor or director should respond in writing to the employees within 2 business days of the request date, thereby granting or denying the request. *(The proper form to use is the “Leave or Clocking Exception Request”).*

**Certification:** When the FMLA leave is to care for the employee’s seriously-ill spouse, child, or parent, or due to the employee’s own serious health condition that makes the employee unable to perform one or more of the essential functions of the employee’s position, UAMS requires that leave be supported by a certification issued by the health care provider of the employee or the employee’s ill family member. *(This form, entitled “Certificate of Health Care Provider”, is available through the Office of Human Resources or at [www.uams.edu/ohr](http://www.uams.edu/ohr) in the forms section.)* When the leave is foreseeable and at least 30 days notice has been provided, the employee should provide the medical certification before the leave begins. When this is not possible, the employee must provide the requested certification to the employee’s supervisor within 15 calendar days from the supervisor’s request.

For extended FMLA leave, the employee may be requested to provide medical certification updates every thirty (30) days. In cases of illness the employee can be required to report periodically to their manager their leave status and their intention to return to work.

If the employee’s absence does not match what the health care provider stated on the Certificate of Health Care Provider form, an updated form can be requested or if the supervisor suspects leave abuse, a health care provider’s note can be requested. *(Ref: Admin Guide, Sick leave 4.6.03)* Also, if the department has questions or needs additional information about what is written on the form, a designated health care provider who represents UAMS will contact the

http://www.uams.edu/adminguide/WIN04611.html

11/3/2005
employee’s health care provider, with the employee’s permission, to clarify or authenticate the medical certification. (Contact the Employee Relations Manager for guidance.) In some instances the form may be returned to the employee for completion if it is obvious that it is not completed in its entirety. Both the FMLA and the Health Insurance Portability and Accountability Act (“HIPAA”) that UAMS obtain authorization prior to seeking this information from the employee’s health care provider. (This form entitled “HIPAA Authorization for release of Information to UAMS” is available in the Office of Human Resources or at [www.uams.edu/ohr](http://www.uams.edu/ohr) in the forms section) The employee is not required to sign the authorization, but if he/she does not, UAMS may not be able to adequately evaluate the request for leave. Under such circumstances, UAMS may deny the request for leave based on the information provided in the employee’s health care certification or require the employee to obtain a second opinion from a health care provider retained by UAMS at its expense.

If there is reason to doubt the validity of the Certification of Health Care Provider, UAMS may require a second opinion from a health care provider it designates. If that opinion differs, the opinion of a third health care provider, jointly approved by the employee and UAMS, may be solicited. That opinion shall be final and binding. UAMS will be responsible for the expenses of the second and third opinions.

As a condition of restoring an employee whose FMLA leave was occasioned by the employee’s own serious health condition that made the employee unable to perform the employee’s job, UAMS may require the employee to obtain and present certification from the employee’s health care provider that the employee is able to resume work. Such “fitness-for-duty certification” may only be sought with regard to the particular health condition that caused the employee’s need for FMLA leave.

**Intermittent and reduced schedule leave:** FMLA leave may be taken intermittently or the employee can work a reduced work schedule under certain circumstances:

- For intermittent leave or leave on a reduced leave schedule, there must be a medical need for leave (as distinguished from voluntary treatments and procedures) and it must be that such medical need can be best accommodated through an intermittent or reduced leave schedule. This medical necessity must be certified by the employee’s health care provider on the Certification of Health Care Provider form.

- Employees needing intermittent FMLA leave or leave on a reduced leave schedule must attempt to schedule their leave so as not to disrupt the University’s operations.

- When an employee requests FMLA intermittent or reduced-schedule leave for any reason, UAMS may temporarily transfer the employee to another available position with equivalent pay and benefits if such a transfer better accommodates the employee’s need for a reduced schedule or intermittent leave.

- Leave may be taken on a reduced leave (part-time) work schedule when approved by the employee’s manager. This will not reduce the total amount of leave entitlement.

- The employee may take intermittent FMLA leave for their own chronic serious health condition if they are unable to perform the essential functions of the job because of this chronic condition. They may also take intermittent FMLA leave to care for a family member that has a chronic serious health condition. The employee or the family member does not have to receive treatment for each episode, but there must be an initial diagnosis by a Health Care Provider and the completed form must be on file with their manager. The Certification Form must contain a statement that the employee is needed to care for the child, spouse or parent and also give an estimate of the amount of time required.

- An expectant mother may take FMLA leave intermittently before the birth of her child and for prenatal care or if her condition causes her to be unable to work.

- Intermittent FMLA leave may be used before the actual placement or adoption of a child and if the absence from work is necessary for the adoption or foster care placement to proceed.

- When the employee takes FMLA leave for the birth of a child or the placement of a child with them for
adoption or foster care, they may take the leave intermittently only if the supervisor agrees to the proposed
arrangement. The part-time arrangement must not exceed the 12 week cumulative limit.

- Management approval is not required if a new mother has a serious health condition connected with the
birth of her child or if the newborn child has a serious condition.

- The employee has two days upon their return to work to advise their manager that their absence was covered
under FMLA (the manager should already have a Certificate for Healthcare Provider Form on file.)

REFERENCES

4.6.08 - Leave of Absence
4.6.07 - Catastrophic Leave
4.1.08 - Workers Compensation
4.6.03 – Sick Leave

[1] For purposes of this policy: “Health Care Provider” refers to a doctor of medicine or osteopathy who is authorized
to practice medicine or surgery by the State in which the doctor practices; or any other person determined by the US
Department of Labor to be capable of providing health care services. This includes clinical social workers who are
authorized to practice under state law, podiatrists, dentists, clinical psychologists, Christian Scientists practitioners,
ophtalmologists and chiropractors (limited to treatment consisting of manual manipulation of the spine to correct a
subluxation as demonstrated to exist by an x-ray), nurse practitioners and nurse-midwives.
POLICY

The State of Arkansas has mandated that all State employees will receive payment for twelve (12) holidays each year, subject to further review and definition by the University Board of Trustees and the University of Arkansas for Medical Sciences (UAMS) Chancellor. Owing to the unique mission of the University of Arkansas System and each individual campus, the days observed may vary, but the total number of days observed remains the same for each agency or institution of the State. The UAMS Office of Human Resources (OHR) will notify all department directors and other appropriate department heads, and all division Deans, Executive Directors and Vice Chancellors of the holiday schedules each year via an attachment to this policy. Additional holidays proclaimed by the Governor will be observed on that day or another, subject to the approval of the Chancellor.

PROCEDURE

(1) All regular, probationary, provisional, and part-time employees, regardless of percent of time worked, shall receive holiday time off in proportion to time worked. A “holiday” is defined as an eight (8) hour period of leave time for a full-time (100%) employee; leave time does not vary according to the daily schedule (8, 10, 12 hour shift) of the employee.

(2) Faculty on nine or ten month contracts who abide by the student time-off schedule shall observe student holidays in lieu of those on the attached Holiday Schedule.

(3) Accrued holidays not taken are payable at the time of termination, but the sum of holiday and vacation hours cannot exceed 240 hours.¹

(4) To be eligible for holiday pay, an employee must be in a pay status on the last scheduled work day before the holiday, and at least one hour on the first scheduled workday after the holiday. Timekeepers will post holiday taken as HOL or HOLF (if counted for FMLA tracking).

(5) When a holiday occurs while an employee is on vacation or sick leave, that day will be charged as a holiday and will not be charged against the employee's vacation or sick leave accruals.

(6) When a holiday falls on an employee's regularly scheduled day off, the employee will be given equivalent time off.

(7) Staff employees must work on any holiday when the needs of the institution require it. The need will be determined by the employee's department director or other appropriate department head.

(8) Days off in lieu of holidays worked may be taken at a time approved by the employee's department director or other appropriate department head. Faculty and senior administrators required to work on a scheduled holiday or a Governor's proclaimed holiday are not eligible for compensatory time-off.

(9) When a holiday, except December 25, occurs on a Saturday, the preceding Friday is observed as a holiday. When December 25 occurs on a Saturday, the following Monday is observed as a holiday. When the holiday, except December 24, occurs on a Sunday, the following Monday is observed as a holiday. When December 24, occurs on a Sunday, the preceding Friday is observed.

(10) Holidays declared by Governor's Proclamation will be observed by departments not involved in patient care activities. Employees who care for patients and are scheduled to work on these proclaimed holidays will not receive time-and-a-half pay. However, they will be entitled to equivalent time-off at a time which is mutually acceptable to the employee and the department director or other appropriate department head.

(11) Employees are to notify their department or other appropriate department head of their request to take their birthday and hire date anniversary time off within a reasonable amount of time.
## 2005 HOLIDAY SCHEDULE

<table>
<thead>
<tr>
<th>Holiday</th>
<th>Date</th>
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<tbody>
<tr>
<td>New Year's Day</td>
<td>December 31, 2004</td>
</tr>
<tr>
<td>Martin Luther King’s Birthday</td>
<td>January 17, 2005</td>
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<tr>
<td>George Washington's Birthday</td>
<td>February 21, 2005</td>
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<tr>
<td>Memorial Day</td>
<td>May 30, 2005</td>
</tr>
<tr>
<td>Independence Day</td>
<td>July 4, 2005</td>
</tr>
<tr>
<td>Labor Day</td>
<td>September 5, 2005</td>
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<tr>
<td>Veteran's Day</td>
<td>November 11, 2005</td>
</tr>
<tr>
<td>Thanksgiving Day (Day after Thanksgiving is a holiday only if declared by the Governor)</td>
<td>November 24, 2005</td>
</tr>
<tr>
<td>Christmas Eve</td>
<td>December 23, 2005</td>
</tr>
<tr>
<td>Christmas Day</td>
<td>December 26, 2005</td>
</tr>
<tr>
<td>Employee’s Birthday</td>
<td></td>
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<tr>
<td>Employee’s Anniversary Date of Hire</td>
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## 2006 HOLIDAY SCHEDULE

<table>
<thead>
<tr>
<th>Holiday</th>
<th>Date</th>
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</thead>
<tbody>
<tr>
<td>New Year's Day</td>
<td>January 2, 2006</td>
</tr>
<tr>
<td>Martin Luther King’s Birthday</td>
<td>January 16, 2006</td>
</tr>
<tr>
<td>George Washington's Birthday</td>
<td>February 20, 2006</td>
</tr>
<tr>
<td>Memorial Day</td>
<td>May 29, 2006</td>
</tr>
<tr>
<td>Independence Day</td>
<td>July 4, 2006</td>
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<tr>
<td>Labor Day</td>
<td>September 4, 2006</td>
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<tr>
<td>Veteran's Day</td>
<td>November 10, 2006</td>
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<tr>
<td>Thanksgiving Day (Day after Thanksgiving is a holiday only if declared by the Governor)</td>
<td>November 23, 2006</td>
</tr>
<tr>
<td>Christmas Eve</td>
<td>December 22, 2006</td>
</tr>
<tr>
<td>Christmas Day [New Year’s Day will be observed on January 1, 2007]</td>
<td>December 25, 2006</td>
</tr>
<tr>
<td>Employee’s Birthday</td>
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<tr>
<td>Employee’s Anniversary Date of Hire</td>
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</tbody>
</table>
PURPOSE

The University of Arkansas for Medical Sciences (UAMS) recognizes that transportation problems result from inclement weather and hazardous road conditions. However, by virtue of our commitment to patient care, academics, and research, this campus never closes. When conditions dictate, the normal work schedule may be revised by excusing late arrivals or permitting early departures. Decisions will be made on an individual case basis for each incident of bad weather or hazardous road conditions.

PROCEDURE

1. In severe weather or hazardous road conditions, the Chancellor or his designated representative will decide if a liberal work schedule excusing late arrivals or permitting early departures will be allowed.

2. The decision of the Chancellor or his designated representative will be conveyed to the Office of Human Resources (OHR) as soon as it has been reached.

3. The OHR will immediately notify all cabinet/division level offices. The administrators within these divisions will be responsible for communicating the decision to all departments reporting to them. Department Chairs and Directors will be responsible for communicating the decision to their staffs.

   - Office of the Vice Chancellor for Academic Affairs
   - Office of the Vice Chancellor for Administration/Legislative Affairs
   - Office of the Vice Chancellor for Finance & CFO
   - Office of the Vice Chancellor for Development
   - Office of the Vice Chancellor for Communications
   - Office of the Dean, College of Medicine
   - Office of the Dean, College of Nursing
   - Office of the Dean, College of Pharmacy
   - Office of the Dean, College of Health Related Professions
   - Office of the Dean, College of Public Health
   - Office of the Dean, Graduate School
   - Office of the Vice Chancellor for Clinical Programs
   - Office of the Vice Chancellor for Campus Operations
   - Office of the AHEC Director
   - Office of the Executive Director, Arkansas Cancer Research Center
   - Office of the Director, Myeloma Institute
   - Office of the Director, Center on Aging
   - Office of the Director, Jones Eye Institute
   - Office of the Director, Jackson T. Stephens Spine Institute

4. In addition to contacting the administrative offices listed above, the Office of Human Resources will also notify the following radio and television stations:
5. The Office of Human Resources may also directly notify, upon request, any other UAMS department whose operations are directly and critically affected by inclement weather.

6. When recording time for an authorized later arrival or early departure, Department Directors or their designated assistants should record the employee's regularly scheduled hours as hours worked.

7. Employees requesting the use of accrued Holiday, Annual Leave or Compensatory Time during inclement weather conditions must obtain approval from their Department Director. Department Directors may approve such requests only after all staffing requirements have been met for the department.

8. Departments adequately staffed, as determined by the Department Director, shall not charge employees for late arrival or early departure (normally two hours). Departments will charge leave for time beyond the normal two hours allowed to employees who arrive late or leave early.

9. Employees absent during inclement weather conditions without approval from their Department Director will be charged for leave of absence without pay, and a disciplinary notice may be issued.

10. Employees of the UAMS Medical Center must also comply with Inclement Weather Policy HR 2.03 of the UAMS Medical Center Policy and Procedures Manual.

REFERENCE

1 UAMS Policy 4.4.01, Basic Code of Conduct
   UAMS Policy 4.4.02, Employee Disciplinary Notice
   UAMS Policy 4.6.08, Leave of Absence Without Pay
PURPOSE

The University of Arkansas for Medical Sciences (UAMS), in conformance with Act 1077 of 1979, Uniform Attendance and Leave Policy, and the University of Arkansas Board of Trustees' University-wide Administrative Memorandum 435.3, Leave Policy for Classified Employees, has established clearly defined uniform procedures under which leaves of absences may be granted and taken. The purpose of this policy is to inform all departments within UAMS of these procedures so that uniformity can be established throughout the campus.

PROCEDURE

1. Employees requesting extended personal leave for reasons other than maternity, extended illness, injury or disability must obtain approval from the University of Arkansas President. Employees requesting such leave of absence must submit the request in writing to the appropriate director or academic head of the department. Upon departmental approval, the request shall be forwarded to the appropriate division Dean, Executive Director or Vice Chancellor for division-level approval, and the division administrator shall then submit the approved request to the UAMS Chancellor for campus approval prior to forwarding it to the University President.

2. The President may grant an employee's written request for a leave of absence without pay not to exceed six months, unless granted in accordance with the provisions of military leave. Employees must submit requests for leave of absence in sufficient time to secure approval prior to the employee's departure.

3. Employees requesting extended leave of absence without pay for reasons of maternity, extended illness, injury or disability may obtain approval from their department or division director without further approval from the University President. Employees requesting such leave of absence must obtain approval from their immediate supervisor and their department director, or division Dean, Executive Director or Vice Chancellor. The department or division director may grant a leave of absence without pay for the above types of leaves for a period not to exceed six months.

4. Departments should change the employee’s status to leave with or without pay in SAP and also indicate the employees expected date of return.

5. Employees on extended leave of absence without pay will retain the same review month, but their next scheduled salary increase should be delayed by the number of months of unpaid leave.

6. Employees shall not be granted leave without pay, except for maternity purposes, until all accumulated annual leave has been exhausted. Also, employees on leave of absence without pay cannot accumulate annual leave, or receive pay for legal holidays. Employees may still be covered under most benefit plans, and should contact the
0HR office to make payment arrangements. Departments will be charged for the department’s normal share of benefits while the employee is on LOA.

7. Maternity leave will be treated as any other leave for sickness or disability; however, employees unable to work because of pregnancy may elect to request a leave of absence without pay, without exhausting accumulated annual leave. However, the department should not put them on leave without pay, until they have used all the accumulated leave they intend to use, unless they also change their percent time. A change in percent time may have an adverse affect on their benefit costs. The departments or employee should contact OHR if they have questions regarding paying leave for maternity leave-s.

8. Departments are responsible for informing employees of the conditions contained in this policy prior to their departure on a leave of absence without pay.

9. Employees eligible for FMLA may have other rights that are covered in policy 4.6.11, Family Medical Leave Act².

10. When an employee returns from their leave of absence they should return to their same or comparable job

REFERENCES
1. 4.6.05 Military Leave
2. 4.6.11 Family Medical Leave Act

http://www.uams.edu/adminguide/WIN04608.html
The University of Arkansas for Medical Sciences (UAMS), in conformance with Act 1077 of 1979, Uniform Attendance and Leave Policy, and the University of Arkansas Board of Trustees' University-wide Administrative Memorandum 435.3, Leave Policy for Classified Employees (including Patient Care Personnel), has established uniform procedures under which military leave may be granted and taken. The purpose of this policy is to inform all departments within UAMS of these procedures so that uniformity can be established throughout the campus.

PROCEDURE

1. Employees who are members of the National Guard or any of the Reserve branches of the Armed Forces of the United States shall be granted up to fifteen (15) working days per calendar year, plus necessary travel time for annual training requirements. Such leave shall be granted without loss of pay and in addition to regular vacation time. Employees requesting military leave must furnish a copy of their military orders to the Office of Human Resources (OHR).

2. Employees drafted or called to active duty in the Armed Forces of the United States, or who volunteers for military service, shall be placed on extended military leave without pay. Upon application, employees shall be reinstated to the position vacated or an equivalent position, without loss of seniority or other employment benefits or privileges, within 90 days of the effective date of release from active duty. Employees who reenlist for a second consecutive tour of military duty shall forfeit all reemployment rights.

3. National Guard and Reserve personnel called to duty in emergencies by the Governor or by the President of the United States shall be granted leave with pay not to exceed 30 working days, after which leave without pay will be granted. This leave shall be granted in addition to regular vacation time.
UNIVERSITYWIDE ADMINISTRATIVE MEMORANDUM

OFF-CAMPUS DUTY ASSIGNMENT

An Off-Campus Duty Assignment is an appointment, usually away from the campus, which allows eligible faculty and administrators to pursue an approved project while being relieved of teaching and administrative duties. The purpose is to enhance the individual's value to the institution.

Faculty members (including research faculty and extension personnel) and non-classified administrators who have completed six years of continuous full-time employment with the University or who have completed six years of continuous full-time service since a previous Off-Campus Duty Assignment may apply for an Off-Campus Duty Assignment. The application, prepared in accordance with campus regulations, must describe the project which the applicant wishes to undertake, where it is to be done, and the anticipated value to the individual and to the University. To be approved, a proposed assignment must be consonant with the needs, objectives, and mission of the campus.

An Off-Campus Duty Assignment is a privilege, not a right. A limited number may be approved by the Board of Trustees each year upon the recommendation of the Chancellor and the President. Assignments should not exceed one semester (or six months for employees on twelve-month appointments) at full salary, or two semesters (or one year for those on twelve-month appointments) at half salary. The University assumes no financial responsibility beyond the salary stated above.

Within sixty days after returning to the campus from an Off-Campus Duty Assignment, the faculty member or administrator must submit a written report of his or her activities and accomplishments during the Off-Campus Duty Assignment to the chairperson of his/her department, the dean of the college, the chief academic officer, the Chancellor, and the President.

In accepting an Off-Campus Duty Assignment, the recipient agrees to return to the University for at least one year following the end of assignment.

April 7, 1990 (Revised)
October 1, 1979 (Revised)
November 3, 1978
PURPOSE

The State of Arkansas and the University of Arkansas for Medical Sciences (UAMS), in conformance with the Arkansas Code Annotated 21-4-201 and OPM policy 105.3 and the University of Arkansas Board of Trustees Policy Statement 420.1 and 420.2, have established uniform procedures under which sick leave may be granted and taken. The purpose of this policy is to inform all departments within UAMS of these procedures so that uniformity can be established throughout the campus.

PROCEDURE

1. All regular, probationary, provisional, and part-time University employees who work 20 hours or more per week shall accrue sick leave. Paid sick leave shall not be granted as vacation leave, and can only be used when the employee is unable to work because of sickness or injury, or for medical, dental or optical treatment. Sick leave may not be borrowed from future credits or advanced beyond actual accrual, regardless of length of service.

2. Sick leave may be granted to employees due to the death or serious illness of a member of the employee's immediate family. The term “immediate family” shall mean the father, mother, sister, brother, spouse, child, grandparent, grandchild, mother-in-law, father-in-law, or any other person acting as a parent or guardian of an employee. The department head may grant sick leave for death or family illness in an amount which is reasonable for the circumstances. ¹

3. All eligible, full-time employees shall accrue sick leave at the rate of eight hours for each complete month of service, up to a maximum of 960 hours or 120 days. Employees working less than full time but 20 hours per week or more shall accrue sick leave in the same proportion to time worked. Sick leave may not be accumulated during a leave without pay when such leave totals ten or more days within a calendar month.

4. Sick leave shall be granted on a basis of workdays rather than calendar days. Used sick leave shall be deducted from the employee's accrued sick leave in increments of not less than 15 minutes (.25 hours). Days off such as weekends and holidays falling within a period of sick leave will not be charged as sick leave. Timekeepers may post sick hours to Accutime (Kronos) as
   - SICK, for normal sickness or bereavement time
   - SICKF, if hours will be counted toward allotment for Family Medical Leave Act (FMLA)

Use of sick leave can be seen in Kronos and in SAP on infotype 2013 and by running transaction PT50.

5. Employees absent due to illness or disability shall be charged for leave according to the following order:
   a) Earned Sick Leave
   b) Earned Annual Leave (At the discretion of the department head. See UAMS Procedure 4.6.04, Annual Leave)
   c) Catastrophic Leave, if applicable
Any time off, paid or unpaid, may qualify as “Family Medical Leave” (FMLA) or may be declared FMLA by the University. 

6. Employees using five (5) or more consecutive days of sick leave must furnish a certificate from an attending physician to their department director or other appropriate department head. Employees absent for reasons of sickness who have exhausted all sick leave may be denied use of earned annual leave, at the discretion of the department head, if abuse of sick leave is suspected. A physician's certificate may also be required in instances where abuse of sick leave is suspected.

7. Employees who leave University employment are not entitled to be paid for accrued sick leave. Employees transferring to another State agency or institution may transfer accrued sick leave. Employees laid off due to budgetary reasons or curtailment of University activities may have all accrued sick leave restored to their credit if they return to University employment within six months. Leave may also be donated to the Catastrophic Sick Leave Bank.

8. Employees absent from work due to a temporary occupational injury or illness, and who are entitled to Worker's Compensation Benefits, may utilize their accrued sick leave, upon proper application, as a supplement to Worker's Compensation and receive weekly benefits from both sources. These combined benefits may be equal to, but not in excess of, the employee's normal weekly pay at the time of injury or onset of illness. This option will reduce accrued sick leave on a basis proportional to the sick leave pay being claimed. Employees receiving Worker's Compensation Benefits for a permanent disability are eligible for full pay from both sources.

9. Maternity leave will be treated as any other leave for sickness or disability. An employee who is unable to work because of pregnancy may use accumulated sick leave and annual leave, and when such accumulations have been exhausted, leave of absence without pay may be granted.

10. Managers or employees with questions regarding bereavement or sick leave should contact the Office of Human Resources at 686-5650.

REFERENCES

1. OPM Policy 105.3, Uniform Attendance and Leave Policy Act
2. UAMS Policy 4.6.11, Family Medical Leave
3. UAMS Policy 4.6.07, Catastrophic Leave
4. UAMS Policy 4.1.08, Worker's Compensation
PURPOSE

Although the University of Arkansas for Medical Sciences (UAMS) remains neutral on all matters of political affiliation or support, it is the policy of the University to encourage all members of the community to support and vote for candidates of their choice in both national and local political elections. In most communities, the polls remain open for a sufficient amount of time to allow employees reasonable time to vote without interruption of their working day. In cases of extreme hardship, or great distance to the polls however, employees may be permitted to arrive late or to depart early from their assigned work stations. This time is to be provided with pay and without the use of annual leave, sick leave, or compensatory time.

PROCEDURE

1. Employees unable to find a reasonable amount of time to vote due to unusual working hours or great distance between this campus and the location of the voting precinct, should inform their immediate supervisor as soon as possible before election day, so that schedules can be arranged to provide adequate coverage.
2. Employees shall be allowed to complete the voting process by either arriving late, or departing early from their assigned work station.
3. The time taken off from work will be considered leave with pay, and Time and Attendance Sheets should reflect this time as "hours worked".
Faculty Resources

4. UAMS Employment Policies, Procedures and Services

Basic Code of Conduct (Admin Policy 4.4.01)

Bookstore Services (Admin Policy 11.1.07)

Campus Motor Pool Vehicle Checkout (Admin Policy 11.1.06)

Career Service Recognition Award (Admin Policy 4.2.08)

Compensatory Time (Admin Policy 4.2.02)

Drug-Free Workplace (Admin Policy 4.4.05)

Excess Effort Hours (Admin Policy 4.2.11)

Flex Schedules (Admin Policy 4.2.03)

Garnishment and Salary Liens (Admin Memorandum 440.9)

Garnishment and Salary Lien Procedure (Admin Policy 4.3.09)

Keys Requests and Transfers (Admin Policy 11.1.04)

Personal Data Change (Admin Policy 4.5.15)

Post Employment Medical Screening (Admin Policy 4.5.18)

Substance Abuse (Admin Policy 4.4.06)

Travel and Reimbursement (Admin Policy Section 8.4)

UAMS ID Badge Issuance and Replacement (Admin Policy 11.3.05)

Use of University Facilities (Admin Memorandum 715.1)

Use of Roofs and Exterior Walls (Admin Memorandum 720.1)

Workplace Violence Prevention Plan (Admin Policy 11.3.07)

A complete listing of Employment Policies in the UAMS Administrative Guide may be found at http://uams.edu/AdminGuide/index.html#Human%20Resources
PURPOSE

The purpose of this policy is to notify departments within the University of Arkansas for Medical Sciences (UAMS) of the procedures to be followed in establishing and communicating a basic code of conduct for all employees. The code is necessary to communicate to all UAMS employees the University's expectations governing employee conduct. It is the responsibility of the department directors and supervisors to fully explain the following procedures to employees, to discuss their specific application within their departments, and to assure that they are observed. Appropriate disciplinary measures must be taken in cases where there have been violations of this Code of Conduct.

PROCEDURE

1. Employees should discuss patient and employee information with authorized personnel only, and in private.
2. Employees are expected to wear their identification badges while on duty.
3. Employees must refrain from using abusive, provocative or profane language, and should avoid creating or being party to a disturbance or physical violence.
4. Employees should observe the principle of mutual respect in their contacts with patients, visitors and students, and in their working relationships with faculty and other employees.
5. Employees should refer to Policy 4.4.09, Ethical Conduct/Gift Policy, regarding gratuities, gifts or personal favors from vendors, patients or visitors.
6. Employees finding property on the University premises must deliver such property to the Public Safety Department where a lost and found service is provided.
7. Employees must follow, within the definitions of the job description, all oral and posted work assignments.
8. Employees must maintain regular and punctual attendance. Departments should follow instructions for reporting absenteeism from work.
9. Employees must not report to work or be on the University premises if under the influence or odor of intoxicating liquor or controlled substances not prescribed by a physician.
10. Employees must obtain permission from their supervisors when it becomes necessary to leave their work areas during working hours.
11. Employees must accurately record their working time, and employees may not record work time of other employees.
12. Employees are expected, whenever possible, to respond to work assignments outside of regularly scheduled hours as may be necessary to provide essential staffing or support services.
13. Because of the large volume of hospital business transacted by telephone, outgoing personal telephone calls are not permitted on University telephones; and, the number of incoming calls must be limited to those of an urgent nature.4
14. Employees must make all packages, handbags, purses, totebags, briefcases, shopping bags or other containers being brought into or taken from the University buildings available for inspection upon request by supervisors or the Public Safety Department.
15. Employees should assist in keeping University equipment, buildings and grounds clean, orderly and in good condition, and should avoid creating or contributing to unsanitary or unsightly conditions.
16. Employees in certain positions are expected to wear prescribed uniforms while on duty. Department directors are responsible for informing employees of specific requirements.
17. Employees are strictly forbidden from sleeping on the job, except while on on-call status.
18. Employees are strictly forbidden from stealing, misappropriating or removing from University premises any property belonging to patients, visitors, students, contractors, or other employees of the University. This includes the removal of University property that has been discarded, and sample products.
19. Employees must not enter inaccurate or false information on any University or hospital records, including patient records, time records, employment applications or other personnel records.
20. Employees must not, under any circumstances, bring unauthorized firearms or weapons of any kind onto the University premises.

21. Employees must always use or operate University property and equipment in a safe and proper manner. Making equipment inoperative or failing to use safety devices can result in injuries to employees or others.  

22. Employees should not engage in horseplay, scuffling, running, throwing objects, or immoral or indecent behavior on the University premises.

23. Employees may engage in solicitation and/or distribution of printed or written material or posting and/or removal of notices or signs only when permitted or authorized in advance to do so.

24. Employees must observe safe work practices and published safety rules.

25. Employees may smoke only in designated areas.  

26. Employees are expected to know and observe established fire and emergency procedures.

27. Employees should not have other employees or guests visit them in work areas.

28. Employees who are not on duty should not be on the University premises, except for valid reasons.

29. Employees must not commit any criminal act on the University premises, or against employees, patients, visitors or students.

30. Employees, when purporting to represent the University, must accurately and honestly represent themselves and their positions to patients, visitors, students, other employees and the general public, and must not use another employee's identification badge.

31. Employees should use only authorized University entrances and exits.

32. Employees should use UAMS property for authorized purposes only.

REFERENCE

1 UAMS Policy 3.1.03
2 UAMS Policy 11.4.01 and UAMS Policy 11.4.15
3 UAMS Policy 3.1.01
The purpose of this policy is to notify departments within the University of Arkansas for Medical Sciences (UAMS) of the procedures for effective use of the UAMS Bookstore and its available services.

PROCEDURE (GENERAL)

1. The UAMS Bookstore is a source for all students, faculty, and staff of UAMS, as well as Arkansas physicians, who wish to obtain medical textbooks and equipment, reference materials, supplies and gift items.

2. The Bookstore is open Monday through Friday, 8:00 a.m. to 4:00 p.m., and is located on the ground floor of the Jeff Banks Student Union. The telephone number is 686-6160, the Fax number is (501) 686-5905, and the mail slot number is Slot 565. All messages or orders to the Bookstore must be clearly labeled.

PROCEDURE (TEXTBOOKS AND SPECIAL ORDERS)

3. Faculty members requesting textbooks from the UAMS Bookstore must submit Textbook Authorization Forms at least two months prior to the first day of class. Classes offered on a regular semester schedule should have textbooks ordered by June 1st for the Fall semester and October 15 for the Spring semester. The Bookstore will distribute a reminder memo and blank Textbook Authorization Forms to faculty members at least six weeks prior to the due date of completed textbook authorizations. Additional blank Textbook Authorization Forms and Desk Copy Order Forms are available in the Bookstore.

4. Books may be special ordered by using Special Order Book Forms available in the Bookstore. Orders can be placed in person, by telephone, by Fax or through mail correspondence. Orders require a fifty percent (50%) down payment at the time of order. Down payments will be forfeited if the order is canceled by the requesting customer. If the order is cancelled by the publisher, the full down payment will be refunded.

5. The University Bookstore will sell textbooks through Interdepartmental Transfers to all UAMS departments at a five percent (5%) discount. Any other item(s) or supplies may also be purchased through Interdepartmental Transfer but will not be subject to the 5% discount. Items available through state contract or through the Stockroom cannot be purchased through Interdepartmental Transfers. When ordering items through Interdepartmental Transfers be sure to include a contact person and their extension number.

PROCEDURE (OTHER ITEMS)

6. The UAMS Bookstore will have specialized supplies available for the various colleges’ students, if the Bookstore manager is notified in writing at least two months prior to the students’ need for these supplies. If special supplies are needed during the semester, the Bookstore manager will obtain these supplies as quickly as possible.

7. Faculty wishing to sell syllabi for their classes may do so through the Bookstore. A small handling fee will be added to the printing cost of the syllabi when it is sold to the students. Departments will receive reimbursement for their printing charges by way of Interdepartmental Transfers based on semester sales of the syllabi.

PROCEDURE (COSTS)

8. Prices for textbooks in the UAMS Bookstore are based on individual publisher’s suggested retail price and include a charge for shipping and handling. An appropriate discount on books is offered to all UAMS students, faculty, and staff and employees who present their UAMS Identification Badge.

9. Personal Checks will be accepted for the amount of purchase when proper identification is presented. Return checks are processed through a collection agency. All inquiries regarding returned checks must be addressed to the UAMS Treasurer’s office. Visa,
Mastercard will also be accepted for purchases.

10. Health checks issued by the UAMS Blood Bank can be used to purchase any item in the UAMS Bookstore.

PROCEDURE (REFUNDS)

11. Books may only be returned within two weeks after the purchase date as printed on the register receipt. No refunds will be made after that two week period.

12. Any item returned for refund or exchange (within two weeks following the purchase date) must be accompanied by a cash register receipt. Refunds for books returned after five working days are reduced by twenty percent (20%) unless accompanied by a signed statement from the college stating that the student has dropped the course.

13. Refunds or exchanges on items besides textbooks will be handled on a case by case basis.

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TEXTBOOK AUTHORIZATION FORM INSTRUCTIONS

GENERAL INFORMATION

The Textbook Authorization Form is sent to faculty members six weeks prior to their due date, which is at least two months prior to the first day of class. Additional copies are available in the Bookstore.

COMPLETING THE FORM

Check the appropriate space indicating the semester and level for which authorization is requested.

1. College: Enter the name of the college requesting authorization of the textbook.
2. Estimated Enrollment: Enter the estimated number of students enrolled.
3. Faculty Name & Ext.: Enter the name and telephone extension of the faculty member making the request.
4. CourseTitle/Number: Enter the complete name and number of the course for which the requested books will be used.
5. Date: Enter the date of this authorization request.

REQUIRED BOOKS/SUPPLIES/EQUIPMENT

These blanks are reserved for the listing of only those books, supplies and equipment that are required for a particular course. Use these blanks for listing textbooks, as well as supplies and equipment.

6. Primary Author: Enter the primary author of the textbook being requested. NOTE: Only current editions are available. Old and out of print titles cannot be ordered.
7. Title/Edition/Year: Enter the complete title, edition, and copyright year of the textbook being requested.
8. Publisher: Enter the name of the textbook’s publisher.

RECOMMENDED BOOKS/SUPPLIES/EQUIPMENT

These blanks are reserved for the listing of only those books, supplies and equipment that are recommended for a particular course. Follow the same steps as in 6-8 above to complete this section.

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DESK COPY REQUEST FORM INSTRUCTIONS

GENERAL INFORMATION

The Desk Copy Request Form is used to request a desk copy of a book previously ordered for a specific course. Publishers and bookstores prefer that instructors write directly to the publishers for desk copies.

COMPLETING THE FORM

1. Date: Enter the date that this request is made.

http://www.uams.edu/adminguide/WIN11107.html

11/3/2005
2. **To:** Enter the full name of the publisher’s street address, and the publisher’s city, state and zip code.

3. **Your Book:** Enter the complete title and edition of the book requested, and indicate the author.

4. **Publisher’s Book Number:** Enter the ISBN if known.

5. **Required of Recommended:** Check the appropriate space indicating whether the book is required or recommended for the course.

6. **Course Number and Title:** Enter the complete number and title of the course.

7. **Number and Name of Bookstore:** Enter the total number of copies that was ordered, and enter the name of the bookstore with which the order was placed.

8. **Date:** Enter the date which the order indicated above was placed.

9. **Name/Rank:** Enter the name and rank of the requesting instructor.

10. **Department:** Enter the name of the department making the request.

11. **School:** Indicate the school that is making the request.

12. **Address:** Enter the complete street address, city and state of the school making the request.

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**SPECIAL ORDER BOOK FORM INSTRUCTIONS**

**GENERAL INFORMATION**

Books may be special ordered by using *Special Order Forms* available in the Bookstore. A fifty percent (50%) down payment is required at the time of the order. Down payments will be forfeit if the order is cancelled by the requesting party. If the order is cancelled by the publisher, the full down payment will be refunded.

**COMPLETING THE FORM**

1. **Name:** Enter your name.

2. **Author:** Enter the full name of the author(s).

3. **Title:** Enter the complete title of the book requested.

4. **ISBN:** (International Standard Book Number) Enter the name of the publisher, since ISBN is not usually known.

5. **Date Ordered:** Leave this space blank.

6. **Price:** Enter the price of the book requested.

7. **Date Paid:** Enter the date that the down payment was made.

8. **Amount Paid:** Enter the amount of the down payment, and check the appropriate blank indicating the method of payment. If the method of payment is a credit card, then enter the credit card number.

9. **Signature/Date:** Enter your signature and the date signed.
PURPOSE

The purpose of this policy is to inform departments within the University of Arkansas for Medical Sciences (UAMS) of the uniform procedures to be followed for the check out of vehicles assigned to the UAMS motor pool. A limited number of vehicles of various types are available for use on a first come, first serve basis. Vehicle use charges vary and are determined by type of vehicle, mileage driven, or by a minimum charge. Exact rates can be obtained by calling extension 66896. During times other than normal duty hours, a vehicle will be available for emergency situations only.

PROCEDURE

1. Departments requiring use of a motor pool vehicle during normal working hours (7:30 a.m. - 4:00 p.m. Monday through Friday) must visit the Physical Plant Warehouse, Room #G505, to prepare the Vehicle Release Forms and to pick up the keys. Departments must provide an account number to be charged for use of the vehicle, and an authorized signature indicating department approval of the indicated method of payment.

2. Upon completion of the Vehicle Release Forms, Physical Plant Warehouse personnel will provide keys, credit cards (when appropriate), and the vehicle location to the authorized requesting department employee. Upon return of the vehicle, the employee must record the speedometer/odometer reading in the space provided on the release form.

3. Reservations for use of motor pool vehicles can be made in advance by calling extension 66896. Cancellations should be made immediately upon discovering the vehicle no longer will be required.

4. Departments requesting vehicles for out-of-state use must submit a memo to the Chancellor for approval.

5. Departments requiring additional information or assistance concerning motor pool vehicles should call Physical Plant Maintenance Control at extension 65400 or the Motor Pool Office at extension 66896.

PROCEDURE (EMERGENCY/AFTEO HOURS USE OF MOTOR POOL VEHICLES)

6. Departments requiring a motor pool vehicle for emergency use, on workdays after 4:00 p.m., or on weekends and holidays must visit Physical Plant Central Control, Room #G166 to complete the Vehicle Release Forms and to pick up the keys. The vehicle will normally be a van or pick-up truck. Upon completion of the Vehicle Release Forms, Physical Plant Central Control will provide the keys, credit cards (when appropriate), and the vehicle location to the authorized requesting department employee.

7. Employees using a motor pool vehicle during emergencies and after normal work hours will be responsible for returning the vehicle to its original location. In the event the original parking space is not available upon return, the employee should park the vehicle in another space and indicate the new location of the vehicle on the back of the Vehicle Release Form. Upon return of the vehicle, the employee must also record the speedometer/odometer reading in the space provided on the release form.

8. Physical Plant Central Control will forward all completed Vehicle Release Forms for emergency use of vehicles to Vehicle Control at the beginning of the next duty day. Vehicle Control will be responsible for billing the appropriate department account for use of the vehicle.

9. Departments requiring additional information or assistance concerning the use or release of a motor pool vehicle after duty hours should call Physical Plant Central Control, extension 66424.
PURPOSE

The University of Arkansas for Medical Sciences (UAMS) recognizes its employees who have completed ten or more years of service. The purpose of this policy is to inform all departments within UAMS of information concerning the career service recognition bonus award for its employees.

POLICY

UAMS follows the guidelines established in State law\(^1\) and policies of the Office of Personnel Management (OPM)\(^2\) for awarding annual bonus payments to staff employees based on ten or more years of service to the State of Arkansas. All non-faculty employees, Classified, Non-Classified Patient Care, Administrative, and non-tenure track academic, are eligible for the bonus, payable yearly on their anniversary date for service in a regular full-time position on the following basis:

<table>
<thead>
<tr>
<th>Whole Years of Service</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 through 14 years</td>
<td>$300</td>
</tr>
<tr>
<td>15 through 19 years</td>
<td>$400</td>
</tr>
<tr>
<td>20 through 24 years</td>
<td>$500</td>
</tr>
<tr>
<td>25 or more years</td>
<td>$600</td>
</tr>
</tbody>
</table>

All periods of full-time service in non-faculty positions will be counted, including:

- service at other State agencies and institutions
- periods of authorized leave where no break in service occurred
- leave for military service where re-employment rights were exercised
- periods of "lay off" or reduction in force due to financial reasons and where the employee resumed service within one year, and
- partial years of service

Service in a student or temporary position, service as a resident or service in a post doctoral fellow or a tenure-track faculty position is excluded from the years-of-service calculation.

Payments under this program are subject to withholding of Federal, State, and FICA taxes. Normal deductions to the University’s optional retirement program are made, where applicable; bonus amounts are not included in formulas for calculating retirement benefits under PERS.\(^3\)

The Office of Human Resources (OHR) is responsible for verifying the length of service in full-time positions, for authorizing and paying amounts as stated, and for maintaining records.

General instructions for the use of SAP/HR (Infotype 0050) are found in the manual “Personnel Administration for Department Users”, at the UAMS Enterprise website. Specific information about Career Bonus process is found in the BPP, “Career Service Bonus and Reporting”, also at the enterprise website. See [http://intranet.uams.edu/enterprise/](http://intranet.uams.edu/enterprise/)

PROCEDURE

1. OHR will verify service from computerized reports of those initially eligible employees, according to the "adjusted date of State service" in their anniversary month. A "Career Service Date" will be established.

2. A program for Career Service Bonus payments is run each month in Human Resources: this produces a “wage type” of “1027” which

http://uams.edu/AdminGuide/WIN04208.html
can be seen on infotype “One-Time Payments Off-Cycle (infotype 0267), found on infotype 0000 “Display HR Master Data”, under the tab “Payroll Data”. A history of payments can be viewed by clicking the “mountain” icon for “overview”.

3. Payment is made by a separate check or direct deposit, which are distributed to the employee through normal department payroll distribution near the end of each month.

4. Bonus payments are charged to a UAMS account when the employee is paid from State Funds (111 or 113). Expense for employees paid from other funds is charged to the normal “cost distribution” found on infotype 0027 at the time of the payment. Employees paid by a mix of “state” and “other” funds will be paid initially from the 0027 cost distribution, with a Budget Office credit back to the department budget for 111 and 113 funds charged to the department.

5. Employees inadvertently omitted from the Bonus payroll will be paid on the next bonus payroll cycle.

6. Questions regarding Career Service Recognition Bonus Payments should be addressed to OHR at 686-5650.

REFERENCES
1 Act 882 of 1989 and Act 556 of 1991
2 AHRMS, OPM Policy, Section 150
3 UAMS Policy 4.1.06, Disability Insurance
PURPOSE

The purpose of this policy is to notify employees of the University of Arkansas for Medical Sciences (UAMS) of procedures to be followed for compensatory time. UAMS is authorized, under a 1986 amendment to the Fair Labor Standards Act (FLSA), to grant its employees compensatory time off in lieu of overtime payment.

General instructions for the use of SAP/HR (Infotype 0050) are found in the manual Personnel Administration for Department Users”, at the UAMS Enterprise website: http://intranet.uams.edu/enterprise/Manuals.htm

POLICY

Employees who hold positions which are non-exempt (“hourly”) under FLSA must be compensated for excess hours worked. For employees who work 40 hours per week, overtime is considered to be any hours worked in excess of 40 hours in a workweek. Employees who are exempt (“salaried”) under FLSA are not required to receive overtime or compensatory time off. Compensatory time should be used to compensate for overtime whenever possible. Under State Law, cash payments may be paid to UAMS employees only in critical circumstances.

“Non-exempt” means “hourly”, a designation which is found in the field “Employee subgroup” on most SAP/HR on most infotypes, with the data “Full time / hourly”, “Part time / hourly” or “Temporary / hourly”. “Exempt” means “salaried” and appears in the same SAP field as “Full time / salaried”, “Part time / salaried”, or “Temporary / Salaried”

PROCEDURE

1. In Accutime (Kronos), hours over 40 in a work week for an “hourly” employee will automatically default to either “comp” or "overtime”. This choice is made in SAP/HR on infotype 0050, “Time Recording” in the field “Grp. att/absence”. The drop-down choices include the designation “OT” or “COMP” which are combined with the minutes to deduct for lunch.

2. Compensatory time off is calculated at a rate of one and one-half times the number of overtime hours worked. For example, an employee who works two hours of overtime in a work week earns three hours of compensatory time off. For employees who routinely clock IN and OUT using Accutime (Kronos), COMPA (comp accrued) is automatically generated when hours worked exceed 40 in a workweek. For employees who do not use clocks, the timekeeper must enter COMPA hours manually into the system. Timekeepers may also move hours from COMPA to OT or from OT to COMPA using the "move" function in Accutime.

3. Compensatory time hours must be tracked manually by the department timekeeper by posting 1.5 hours of future time off for every hour of COMPA earned by the employee. The maximum accrual level of compensatory time allowed by law is 240 hours for 160 hours of COMPA. Public Safety Officers may accrue up to 480 compensatory time off hours for 320 hours of COMPA. Once these maximums are reached, any additional overtime must be paid in cash and posted in Accutime as OT.

4. Employees wishing to use accrued compensatory time hours must make a written request to their supervisor. Supervisors may also determine when comp time must be used and advise the employee to take time-off as designated. When considering compensatory time requests, the needs of the employee must be balanced with the operational needs of the department. Compensatory hours are posted in Accutime (Kronos) as COMPU (comp used). The department timekeeper should manually reduce the “comp balance” of available hours for the employee by the number of COMPU hours posted.

5. Non-Exempt (“hourly”) employees who leave UAMS employment are entitled to payment for any accrued, unused compensatory time. Compensatory hours will be paid at the last rate of pay immediately prior to separation, or the average rate of pay.
pay for the three prior years, whichever is greater. Timekeepers should post COMPU hours along with any TERMLV (terminal
leave) hours to be paid to the Accutime Timecard Employees requesting further information on compensatory time may contact the
Office of Human Resources at 686-5650.

REFERENCE
UAMS Policy 4.2.01, "Overtime Compensation"
UAMS Policy 4.2.11, "Paying Excess Hours for Exempt Personnel"
The University of Arkansas for Medical Sciences (UAMS) supports the concept of a drug-free workplace, as enacted in the Federal Drug-Free Workplace Act of 1988 and the State of Arkansas Executive Order EO-89-2, issued March 30, 1989. It is the policy of the State of Arkansas, and thereby the University of Arkansas for Medical Sciences, that the unlawful manufacture, distribution, dispensation, possession or use of a controlled substance in a UAMS workplace or by an employee while on a University assignment is prohibited. However, nothing in this policy precludes the medical or research use of alcohol or controlled substances. UAMS will not differentiate between drug users and drug pushers or sellers in the applicability or enforcement of this policy.

**PROCEDURE**

1. Employees are informed through orientation and published literature about the dangers of drug abuse in the workplace and the UAMS policy of maintaining a drug-free workplace. Also the available counseling, rehabilitative services, and the penalties imposed for drug abuse violations.

2. The UAMS Office of Human Resources will provide all new employees with the *UAMS Drug-Free Awareness Statement* at orientation, and each employee will be required to sign the Statement at that time. The Office of Human Resources is responsible for collection and retention of all signed statements.

3. Any UAMS employee who illegally uses, gives, sells, or in any way transfers a controlled substance to another person, or manufactures a controlled substance while on the job or on UAMS premises will be subject to discipline up to and including termination.

4. UAMS recognizes that addiction to drugs represents a disease state and that treatment of such problems is a legitimate part of medical practice. Any employee who recognizes such addiction or problem is encouraged to seek assistance as specified in the UAMS Substance Abuse Policy. Employees will not be disciplined for seeking such help, although disciplinary procedures linked to performance criteria are still applicable.

5. The Drug-Free Workplace Act of 1988 requires contractors and grantees of federal agencies to certify that they will provide a drug-free workplace. The Office of the Vice Chancellor for Academic Affairs and Sponsored Research are responsible for certifying UAMS as a drug-free workplace for all grant and contract employees.

6. The Office of Human Resources will identify all employees working with federal grant or contract funds and will provide each employee with a copy of this policy and the *UAMS Drug-Free Awareness Statement* (Page 3). As a condition of employment on such a grant or contract, the employee must abide by the terms of the Statement.

7. Grant and contract employees must notify their supervisor and the Office of Research Administration of any criminal drug statute conviction for a violation occurring in the workplace, no later than five (5) days after such conviction. The Office of the Vice Chancellor for Academic Affairs and Sponsored Research will be responsible for notifying the appropriate granting agency when a violation of a criminal drug statute by such employee has occurred on UAMS premises.

**DEFINITIONS**

1. The term *conviction* shall mean a finding of guilt (including a plea of nolo contendre) or the imposition of a sentence by a judge or jury in any federal or state court, or other court of competent jurisdiction.

2. The term *controlled substance* shall mean any drug listed in Volume 21 of United States Code (U.S.C.) Section 812 or in any other federal regulations. Generally, these are drugs, which have a high potential for abuse, including but not limited to Heroin, Marijuana, Cocaine, PCP, "crack," and "legal drugs" which are not prescribed by a licensed physician.

3. The term *workplace* shall mean UAMS property and all places designated for employees during the course of any University affiliated assignment.

**REFERENCE**

UAMS Policy 4.4.06, Substance Abuse
UAMS ADMINISTRATIVE GUIDE

NUMBER: 4.2.11
DATE: 09/01/00
REVISION: 07/01/2003

SECTION: HUMAN RESOURCES
AREA: COMPENSATION
SUBJECT: PAYING EXCESS EFFORT HOURS FOR EXEMPT NON-CLASSIFIED PERSONNEL

PURPOSE

UAMS recognizes the commitment and dedication made by "exempt" ("salaried") personnel (see Definitions, Policy 4.2.01) in the successes of all units, departments, and divisions. While there is no legal obligation to pay for overtime or for excessive effort, the State of Arkansas allows payment to non-classified exempt employees where the institution establishes uniform conditions, as outlined in this policy.

PROCEDURE

1. Non-classified employees who occupy "exempt" ("salaried") positions are not legally entitled to "overtime" or payment for hours in excess of the normal work schedule, according to the Federal Fair Labor Standards Act (FLSA). SAP/HR field “Employee subgroup” appears on most infotypes as “Full Time/Salaried”, “Part Time/Salaried”, or “Temporary/Salaried”.

2. A department head may credit an employee with "excessive effort" when such work meets all of the following criteria: effort:
   - The employee was directed to perform necessary tasks outside the normal hours of work.
   - The work was of short duration and was not a routine and on-going assignment.
   - The work is not routine supervisory work (applies only to exempt supervisor).

3. At such time when it appears that compensatory time off is not practical; the department head may recommend that "excessive effort" (remaining after all attempts at compensatory time off) be paid in the following manner:

4. When all approvals are obtained, the department will send the memorandum or email to the Office of Human Resources, who will load into SAP/HR for payment as a “one time payment off-cycle”. A payment separate from normal monthly pay will be issued.
   a. The department head will submit a memorandum or email stating the reason(s) for the excessive effort and the reason(s) time off was not applied, together with the amount of payment requested. Since these are “salaried” employees, the amount of pay cannot be stated as or paid as a number of hours worked or hours times an hourly rate of pay: a rounded “value” of the service must be stated.
   b. The division executive (Dean, Vice Chancellor, or Executive Director) and the Office of Human Resources must approve the recommendation. Where the “excess effort” was worked in a division different from the employee’s division (or where funding is provided by another division), both division executives must agree to the payment. NOTE: some division executives require that you gain their approval prior to assigning the extra work which generates the “excess effort”

5. Payments will be charged to normal salary accounts, unless the department specifies the cost center or WBS element to bear the expense: only one account may be charged for each payment.

REFERENCE

General instructions for the use of SAP/HR (including the field “employee subgroup”) are found in the manual “Personnel Administration for Department Users”, at the UAMS Enterprise website: http://intranet.uams.edu/enterprise/Manuals.htm

PURPOSE

UAMS has established the hours of operation for the institution and delegated to its department heads the authority to establish hours of work and to assign working hours for each employee based on the operational needs of the department.

POLICY

Department heads are encouraged to balance operational needs with the needs of the employees, including the privilege of establishing mutually agreeable non-traditional start and stop times, commonly termed "flextime." Departments must adhere to the Federal Fair Labor Standards Act (FLSA) in the payment for time worked for nonexempt ("hourly") personnel¹, and to the rules on shift differential payment.²

Except in case of an emergency, changes in the routinely assigned work schedule should be communicated to the employee at least two weeks prior to the change.³

PROCEDURE

1. Departments should define and publicize standard hours of operation and normal schedules of work for employees.

2. The concept of "flexible hours" generally involves the staggering of the start and stop times for various staff while still accomplishing the mission and workload. For example, a normal office schedule of 8:00 a.m. to 5:00 p.m. with an hour lunch could be flexible by allowing individuals to work 7:00 a.m. to 4:00 p.m., 7:30 a.m. to 4:30 p.m., 8:30 a.m. to 5:30 p.m. or 9:00 a.m. to 6:00 p.m. Flexible hours in other environments might mean shifting staffing patterns to coincide with heavier workload of patients, students, or other work, while scheduling fewer people during the lighter portions of the day or week. These might result in weekend only schedules, 4-day workweek, 12-hour days and the like.

3. A department wishing to establish flexible work hours or shifts should generally allow employees to volunteer to work such hours/shift prior to involuntary assignment. Involuntary assignment must follow the two-week notice rule, as mentioned above.

4. An employee wishing to work flexible hours or otherwise change the hours of work should make a proposal to the immediate supervisor or department head, including any benefit for the department of such a schedule change.

5. The agreement should be committed to writing so that there will be no misunderstanding regarding tardiness or absenteeism.

6. The department head may limit the privilege of flexible hours based on the operational needs of the department or on any misuse of the privilege by the employee.

7. Questions regarding flexible schedules and their impact on FLSA overtime rules, shift differential or other issues should be addressed to OHR at 686-5650.

REFERENCES

¹ UAMS Policy 4.2.01, "Overtime Compensation"
² UAMS Policy 4.2.04, "Shift Differential"
³ UAMS Policy 4.3.02, "Definition of Workday, Work Shift, and Pay Periods"
GARNISHMENT AND SALARY LIENS

Any University employee is legally subject to having wages and/or other amounts due from the University seized by a court order of garnishment or by a governmental lien. The University is required to comply with an order of garnishment only where it is issued after a legal judgment has been entered against the employee-debtor. Governmental liens such as those arising from claims for unpaid taxes and from bankruptcy claims must also be honored.

When the University receives such court order or lien, it must pay over the appropriate amount to the clerk of the court or to the governmental agency. Your defenses should be made to them.

For garnishments against compensation due an employee, federal law restricts the amount which may be seized for any one work week to 25% of disposable earnings or the amount by which disposable earnings exceed thirty times the federal minimum hourly wage, whichever is less. (Computation for a month is based upon 4-1/3 work weeks.) Disposable earnings are earnings remaining after deductions required by law to be withheld. These restrictions do not apply where the seizure is one of the following types: (a) court order for support of a person; (b) court order of bankruptcy under Chapter XIII of the Bankruptcy Act; (c) debt due for State or Federal taxes; or (d) amount due employees by University is other than compensation for personal services.

The University has a concern when an employee has a garnishment or salary lien issued against him and served upon the University. A substantial amount of administrative time and expense is involved for the University in processing such court orders and liens.

Upon receipt of two orders of garnishment, two salary liens, or a combination of one of each type of seizure against the salary of a University employee during any period of twelve months, dating from the receipt of the first such order, grounds shall be deemed to exist for termination of such employee according to regular University procedures. For this purpose, multiple garnishment orders arising from the same debt or same judgment shall be treated as a single garnishment, and multiple assertions of salary liens arising out of the same bankruptcy order or same debt for taxes due the same governmental unit shall be treated as a single salary lien.

The University official responsible for responding to judgments of garnishment and liens shall notify the chief administrative officer on his campus when two orders are received against an employee within a twelve-month period.

October 27, 1976
UAMS ADMINISTRATIVE GUIDE

NUMBER: 4.3.09  
DATE: 07/01/91  
REVISION: 12/17/03

SECTION: HUMAN RESOURCES  
AREA: PAYROLL  
SUBJECT: GARNISHMENT AND SALARY LIEN PROCEDURE

PURPOSE

The purpose of this policy is to notify departments within the University of Arkansas for Medical Sciences (UAMS) of the procedures in place to comply with child support orders, garnishment orders and tax liens.

POLICY

The University of Arkansas for Medical Sciences is legally bound to act in response to all court orders and federal tax levies seeking to seize employee earnings. Notices of liens for back taxes, for child support, garnishments, etc. will be processed by the payroll office. The payroll office is responsible for institutional compliance honoring all such legal judgments or government liens.

GARNISHMENTS

Included in this section:

Bankruptcy, Orders for back taxes except from the IRS, Student Loans and Child Support

(1) Upon receipt of all garnishment documents, the payroll office will prepare an answer providing the requested information to the court or other authority.

(2) The payroll office will notify the affected employee of the amount of the garnishment by campus mail.

(3) The payroll office will begin payroll deductions from the employee and transmit them per the court order.

IRS SALARY LIENS

(4) Upon receipt of a Notice of Levy on Wages, Salary or Other Income from the Internal Revenue Service, the payroll office will forward a copy to the affected employee for information concerning exemption and withholding information. The employee will be sent two notices, one by Campus Mail and one by certified mail to the employee’s home address.

(5) Upon determination of appropriate exemptions, the payroll office will calculate the proper amount to be deducted and will process a payroll deduction. The deduction may be cancelled only by a written release of lien from the IRS.

(6) The payroll office will transmit the payroll deduction check as directed by the IRS.

http://www.uams.edu/adminguide/WIN04309.html
**UAMS ADMINISTRATIVE GUIDE**

**NUMBER:** 11.1.04  
**DATE:** 8/25/00  
**REVISION:**

**SECTION:** CAMPUS OPERATIONS  
**AREA:** GENERAL  
**SUBJECT:** KEY REQUESTS/TRANSFERS

**PURPOSE**

The purpose of this policy is to inform departments within the University of Arkansas for Medical Sciences (UAMS) of the uniform procedures for requesting and managing keys for faculty and staff of the University.

**POLICY**

All facility keys remain the property of UAMS and are controlled by the Office of the Director of Physical Plant. The security of UAMS facilities is dependent upon responsible department authorization and the appropriate control and use of keys by faculty and staff. Lost or stolen keys must be reported immediately to the 1) UAMS Police Department, 2) department Dean or Director, and 3) Physical Plant Department. The indiscriminate loaning of keys is prohibited.

**PROCEDURE**

1. **Physical Plant Key Office Hours:** The Physical Plant Key Office hours are as follows:
   
   7:30 am – 9:00 am  
   11:30 am – 12:30 pm  
   3:00 pm – 4:00 pm

2. Requesting Keys: Departments requesting keys for faculty or staff must submit a key request card. Key request cards may be mailed to the Physical Plant Key Office at slot 579, or delivered directly to the key office. There is also a drop box at the key office service window.

   Key request cards must be filled out completely and have an authorized signature. Cards with incomplete data will be returned to the department.

   Key request cards can be obtained from the Physical Plant Key Office or the Physical Plant Materials Management service window, both of which are located on the ground floor of the Physical Plant.

3. Receipt of Keys: To pick up keys, faculty or staff must display their UAMS identification badge at the Physical Plant Key Office and sign & date the key request card. **Keys may not be picked up by proxy.**

4. Transferring Employees: Key transfers to other employees are not permitted. All keys must be returned to the Physical Plant Key Office by the person to whom they were issued. Keys can then be issued to another employee, in accordance with this policy and procedure. It is the department’s responsibility to ensure that transferring employees return all keys.

5. Terminating Employees: Terminating faculty or staff shall return all keys to the Physical Plant Key Office as a part of the clearance procedure. Faculty or staff will be charged for all unaccounted keys. The key office will not sign off on the clearance form until all keys and access cards have been returned or appropriate charges have been paid. The person's department shall not sign off on the clearance form until the person has appropriately cleared through the key office. If faculty or staff does not pay for unaccounted keys, the authorizing department will be charged.

6. Lost or Stolen Keys: Faculty or staff must report lost or stolen keys immediately to 1) the UAMS Police Department, 2) department Dean or Director, and 3) the Physical Plant Department. Faculty or staff will be charged for all lost or stolen keys, or the person's department may take responsibility for paying the charges. Key requests cards for replacement of lost or stolen keys must be...
accompanied by the UAMS Police report and either cash, check, or a work order to pay the charges.

A department may be charged the total cost of re-keying an entire area, department, or building, if it becomes necessary because of a breach of security resulting from lost or stolen keys.

7. Worn or Broken Keys: Worn or broken keys will be replaced at no charge if all parts of the key are returned to the Physical Plant Key Office. The physical plant locksmith can extract a portion of the key that remains in the keyway.

8. Key Levels: The level of keys for UAMS facilities is Operational, Sub-Master, Master, Physical Plant Master, and Great Grand Master.

- Operational. The designated representative of the respective department or area must approve all operational key requests.
- Sub-Master. The designated representative of the respective building must approve all sub-master key requests.
- Master. The designated representative of the respective building and the Executive Director of Campus Operations or Director of Physical Plant must approve all building master key requests.
- Physical Plant Master. The Director of Physical Plant must approve all PPM key requests.
- Great Grand Master. Only the Executive Director of Campus Operations or Director of Physical Plant can approve the issuance a GGM key.

9. Key Charges: Operational $10.00  
Sub-Master $15.00  
Master $25.00  
Great Grand Master $50.00

10. Restricted Access: Departments requesting doors, locks, pad locks, or combination locks not keyed to the UAMS master system must first obtain permission from the Executive Director of Campus Operations. In addition, the department must provide a key or the combination to UAMS Campus Police.

The Physical Plant Key Office can provide a standard V-Series combination door lock with the combination selected and kept confidential by the department, which can only be overridden with a GGM key.

11. Authorized Signatures: Authorized signature forms are kept on file in the Physical Plant Key Office. Keys will not be issued if a key request card does not have an authorized signature matching these records. The key office should be notified of changes regarding department authorized signatures, in order to keep these records current. The key office may periodically request departments to submit current authorized signature forms.

12. Key and Access Card Audits: The Physical Plant Key Office periodically conducts key audits to ensure that accurate records are maintained. Departments will be charged for any unaccounted keys discovered by an audit.

Sample Key Authorization & Request Card: Key request cards are available at the Physical Plant Key Office or Materials Management window, both of which are located on the ground floor of the Physical Plant.

UAMS Key Authorization & Request  
Campus Policy 11.1.04

Keyholder Last Name (print) ___________________________________________  First Name (print) __________________________

Social Security Number __________________________ Telephone Number __________________________

Building/Department for which key is requested __________________________ Room No. (or Key No.) __________________________

Requesting Department (print) __________________________________________ Account Number __________________________

Department Authorized Signature __________________________ Date _______/_____/______

POLICY

Any change involving an employee's personal or biographical information requires appropriate notification be made to the Office of Human Resources or the employee’s department business office. This notification will be made by the employee updating *An Employee Personal Data Change form*.

PROCEDURE

1. A New Employee Data Sheet for all new employees will be completed by the employee at orientation or at time of sign-up onto payroll.[1]

2. Current employees wishing to make changes to their personal data must complete the Employee Personal Data Change form and submit it to the employee’s department business office or the Office of Human Resources. The department business office may key the changes directly into SAP. If an employee is changing their name, then the Employee Personal Data Change form must be forwarded to the Office of Human Resources who will input the change into SAP.

3. The employee is responsible for the accuracy of all employee personal data. Improperly completed forms will be returned to the employee for correction.

4. The Personal Data Change form will change your records for UAMS email, phone directory, QualChoice, Delta Dental, Fidelity and TIAA-CREF. It will not, however, change your records with the credit union, Patient Business Services or MCPG.

1  UAMS Procedure 4.7.01 – New Employee Orientation

**Employee Personal Data Change**

<table>
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<tbody>
<tr>
<td>Your Name: (as currently shown in our records)</td>
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<tr>
<td>Your Employee #:</td>
</tr>
<tr>
<td>(SAP or Social Security #)</td>
</tr>
<tr>
<td>Daytime Phone #: (should we need to contact you)</td>
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</tbody>
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<tr>
<th><strong>New Name:</strong></th>
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<th><strong>New Home Address:</strong></th>
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<td>city        state      zip</td>
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<th><strong>New Home Phone Number:</strong></th>
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<th><strong>Emergency Notification:</strong></th>
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<tr>
<td>Address: ____________________</td>
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<td>___________________________</td>
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<tr>
<td>Phone: ______________________</td>
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<tr>
<td>Relationship: ________________</td>
</tr>
</tbody>
</table>

<table>
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<tr>
<th><strong>Other Miscellaneous Personal Changes:</strong></th>
</tr>
</thead>
</table>

-  

**Your Signature:** _____________________________  **Today’s Date:** ______________________

Thanks for updating your records! Return this form to the Office of Human Resources, # 564  

–fax 603-1318
PURPOSE

The purpose of this policy is to minimize potential exposure to infectious disease for all UAMS employees, students, volunteers, patients, and visitors. UAMS strives to ensure all employees can perform the essential functions of their jobs with reasonable accommodation, and without undue risk of injury to themselves, their co-workers, or UAMS patients. To accomplish these goals, all UAMS employees are required to complete an initial medical screening and an annual, limited, screening which will be conducted twelve months following the date of their previous screening.

POLICY

The employee medical screening is performed within thirty-one calendar days of the date of hire for all new employees. Annual (limited) medical screenings are required for employees during the duration of their employment with UAMS. The new employee medical screening and annual medical screenings are a condition of employment with UAMS. Supervisors are required to allow “released, paid time” from work for an employee to fulfill this requirement.

All newly hired employees who attend new employee orientation will be scheduled for their medical screening at that time. Those not attending orientation should be scheduled within the first thirty-one calendar days of employment. It is the responsibility of the department head to notify the employee if they are required to attend orientation and complete their Employment Medical Screening.

The initial new employee medical screening will minimally consist of a medical assessment (i.e., blood pressure, listing of known allergies, special job accommodations, and tobacco cessation assistance), review of immunizations (MMR, Hepatitis B, and Tetanus,) history of chicken pox (Varicella,) and the placement and reading of a Tuberculin Skin Test (TST.)

If the new employee has not completed the Employment Medical Screening within thirty-one calendar days from their hire date, the employee’s department head will be notified by Student and Employee Health Services (SEHS.) Adherence to the above mentioned policies and procedures for new employees is a condition for employment at UAMS.

Employment Medical Screenings will be conducted for those employees stationed in Pulaski County at either of the two SEHS locations; 1) Student & Employee Health Services clinic located in back of the Family Medical Center (ground level,) or 2) the Satellite Clinic located on the 8th floor, Rm8035, of the main hospital. Employees working outside of Pulaski County must be screened, either at one of the two SEHS locations or, with the consent of their supervisor, by making their own arrangements with an AHEC unit or with their private physician. All required documentation must be provided to SEHS within thirty-one calendar days from their date of hire.

Annual medical screenings will minimally consist of a Tuberculin Skin Test (TST.) The employee may supply documented proof of a Tuberculin skin test, (or health card,) obtained within twelve months of their previous annual medical screening date. Employees who have a documented past positive TST reading will complete the Tuberculosis Screening for Reactors which can be conducted over the phone by calling the SEHS office at 686-6565.
forms may also be returned by mail to SEHS, Mail Slot #530-8.

The nature of an employee’s job, location, and patient contact, may dictate the need for additional TB testing. Employees working in high risk areas will be identified by Occupational Health & Safety and their Departmental Manager. The employee will be notified, by their Manager, of their “TB team” status and instructed to receive bi-annual TB screenings.

SEHS will report the results of the new employee and annual medical screening, on an exception basis only. The employee and the employee’s Departmental Manager will be notified if the employee fails to meet essential physical requirements or poses a threat to themselves or others.

If an employee disagrees with the medical screening report, they may elect to secure a second opinion at their own expense. Results must be presented to SEHS within two weeks of notification to SEHS of the employee’s request for the second opinion.

If the two medical opinions disagree, UAMS Medical Center’s Medical Director will make the final determination on the medical status of the employee. The determination of the Medical Director will be reported to the employee and SEHS, in writing, within two weeks following receipt of the second opinion.

If it is determined that special job accommodations are required for an employee to perform their job functions, SEHS will work with Occupational Health and Safety and Human Resources to determine if reasonable accommodations, or performance of job without undue risk of injury to self and others, can be achieved.

Employment may be terminated if the employee cannot perform the essential functions of the job with reasonable accommodation, or if they present an undue risk of injury to themselves or others. The Office of Human Resources will notify the employee and the department in writing of the decision to terminate employment.

All medical records, including the results of all medical screenings, will be maintained by Student and Employee Health Services (SEHS). All employee medical records will be maintained confidentially. A copy of the medical record may be requested by the employee by contacting the SEHS office.

All physicians, students, and faculty seeking privileges at UAMS must comply with TB testing policies in place for UAMS employees.

PROCEDURE (New Employee Medical Screening)

I. REQUIRED SCREENING:

TUBERCULIN SKIN TEST (TST):

All new employees will require a baseline Tuberculin Skin Test (TST.) The new employee may provide documented proof of a TB skin test as long as it has been no longer than twelve months prior to UAMS hire date. This documented TST will count toward one of the two required readings of the baseline TST.

The baseline TST will include a two-step process if the new employee has; 1) never had a TST or has no documentation of TST, or 2) if it has been greater than twelve months since the new employee had a documented, negative, TST reading result. The first TST will be placed at orientation or at the employee’s New Employment Medical Screening. The two-step process will require the employee to return within 10 – 21 calendar days for the 2nd placement and reading which will then be recorded as the baseline Tuberculin Skin Test.

The baseline TST includes employees with a prior Bacille Calmette-Guerin vaccination (BCG). At the employee’s request, a half dose, (two and one-half (2.5) tuberculin units, or 0.05 ml,) may be applied during skin tests for employees with a history of BCG or previous (undocumented) positive reactions. However, the employee must
understand that, if the half dose test results in a negative TST, a second placement of the full dose of 0.10 ml will be required. The results of the 2nd placement and reading will be recorded as the baseline TST.

For persons vaccinated with BCG, the probability that a TST with a positive reaction is a result of infection with TB increases; 1) as the size of the reaction increases, 2) as the person encounters persons with active TB, 3) if the employee’s country of origin has a high prevalence of TB, and, 4) the length of time between vaccination with BCG and the placement of a TST increases. A positive TST, with a reaction of greater than or equal to 10mm, probably can be attributed to TB infection in an adult who was vaccinated with BCG as a child and who is from a country with a high prevalence of TB.

For new employees, all reported, prior positive Tuberculin Skin Tests must provide documented proof which must include the name and address of provider, date applied, size (in millimeters) of induration, date read, and signature of provider.

Documentation of chest radiography must include the name and address of provider, date performed, interpretation, interpreter’s signature, printed or typed name of interpreter, and identification of interpreter’s medical specialty (which must be radiology, pulmonology, or infectious disease.)

If no documented proof of a past positive is available, a TST will be placed and read with 48-72 hours. The employee may request the TST be done with one-half dose (2.5 tuberculin units or 0.05ml). If the TST is positive, the reading will then be recorded in millimeters of induration for UAMS baseline records. However, the employee must understand that, if the half dose test results in a negative TST, a second placement of the full dose 0.10 ml, will be required with the results of the 2nd placement and reading being recorded as the baseline TST.

Employees with existing medical conditions, which prohibit them from participating in the TST process, should contact SEHS. Arrangements will be made in a confidential manner (with the Department of Health) to complete the annual medical screening requirements.

Employees with an induration of 0 - 4mm will be recorded as negative.

(A negative test does not rule out the presence of TB.)

Employees with a TST induration of 5-9mm will be considered intermediate. Intermediate skin tests will be repeated on the day of 1st reading with the 2nd placement and reading (recorded within 48-72) as the TST result.

An induration of >5mm may be considered “positive” in the following groups:

1) Contact with an active case of TB
2) HIV positive persons
3) Chest x-rays consistent with old, healed TB
4) Recipients of organ transplants, and other immunosuppressed conditions (receiving the equivalent of >15mg/day of prednisone for > 1 month)

Employees with a TST induration of 10 millimeters or greater will be referred to the Arkansas Department of Health (ADH) for further evaluation and preventive therapy if indicated. The chest radiography will be performed at the Pulaski County Health Unit and reviewed by a Radiologist at the unit.

The specialist at the ADH will determine whether the employee does/does not have an active case of TB. If no signs of active TB are found, a temporary health card will be issued by the Health Department to the employee. The employee must then provide a copy of the Health Card to SEHS before they are cleared for the workplace.

The Epidemiologist at ADH maintains TB surveillance of UAMS for several situations. They are; a) the occurrence of true TB skin test "conversions" or "active" TB in employees, b) the occurrence of possible person-to-person transmission of TB and, c) situations in which patients or employees with active TB are not promptly identified and isolated, thus exposing others to TB.

Conversions are defined as “an increase in induration of greater than or equal to 10mm over a two-year period.” Positive TB skin tests are defined as an induration of greater than, or equal to, 10mm as the Tuberculin Skin Test reading.

Employees with a positive TB skin test reaction are required to have a radiograph which meets with the requirements of the TB Control Officer for the State of Arkansas. The employee can provide documentation that they have completed an adequate course of treatment for latent TB infection along with a negative initial radiograph. This information will be forwarded to the TB Control Officer. Only the TB Control Officer for the State of Arkansas, or his designee, may determine the adequacy of a course of treatment, or documentation of treatment, resulting from a positive TST.

Employees who have been determined by the TB Control Officer for the State of Arkansas to have latent TB infection and are receiving preventive treatment, or are unable to, or choose not to accept or complete their preventive treatment, should not be excluded from the workplace.

Employees with radiographic findings consistent with active TB disease will be required to seek additional evaluation and/or treatment to ensure the employee does not pose a risk of TB infection to others. The employee will be notified and instructed to remove themselves from the workplace until, a) a diagnosis of TB is ruled out OR, b) a diagnosis of TB is established, the employee receives treatment, and a determination has been made that the employee is non-infectious. Only the Tuberculosis Control Officer for the State of Arkansas, or his designee, may determine the adequacy of a course of treatment or documentation of treatment for an active case of TB disease.

Employees with TB at sites other than the lung or larynx usually do not need to be excluded from workplace if a diagnosis of concurrent pulmonary TB has been ruled out.

The nature of the employee’s job, location, and patient contact may dictate the need for more frequent TB testing. Employees who are exposed to patients with active TB, areas where diagnostic or treatment procedures that stimulate coughing are performed, clinic waiting areas, and emergency departments, are some examples of high risk areas.

Employees who refuse to comply with the required TST will be referred to the Arkansas Department of Health and their supervisor will be notified.

II. STRONGLY RECOMMENDED IMMUNIZATIONS:

ALL EMPLOYEES:

MEASLES, MUMPS, AND RUBELLA (MMR)

Medical personnel are at higher risk for acquiring measles than the general population. The following Measles, Mumps, and Rubella (MMR) vaccine is strongly recommended for employees at UAMS: new employees born in, or after, 1957 will be asked to provide documented proof of the following:

1. Two doses of live measles vaccine on or after their first birthday (at least one month apart)
2. Documentation of physician-diagnosed measles
3. Laboratory evidence of measles immunity (reactive titer)

Persons born in or after 1957, who do not have documentation of vaccination or other evidence of measles immunity, will be asked to receive the MMR vaccination at the time of employment. In addition, birth before 1957 does not guarantee mumps immunity. Therefore, during mumps outbreaks, MMR vaccination will be considered for persons
born before 1957 who may be exposed to mumps and who may be susceptible. Susceptible personnel who have been exposed should be relieved from direct patient contact from the fifth to the 21st day after exposure regardless of whether they received vaccine or IG after the exposure. Personnel who become ill should be relieved from patient contact for seven days after they develop rash.

**Exceptions:** Pregnancy or anticipated pregnancy within three months following vaccine, previous allergic reaction to the vaccine, persons who have experienced anaphylactic reactions to neomycin, and persons with immune-deficiency diseases and persons with immunosuppression (i.e., leukemia, lymphoma, generalized malignancy, or therapy with alkylating agents, antimetabolites, radiation, or large doses of corticosteroids. Measles vaccine should not be given for at least six weeks to three months, after a person has been given IG, whole blood, or anti-body-containing blood products. Minor illnesses, such as a mild upper-respiratory infection, with or without low-grade fever, are not considered a contraindication for the vaccine.

**REMINDER: Some employees require a 2-step TST.** The MMR vaccine should not be given until the day of placement, or following the reading of, the 2nd placement of a 2-step TST. If this is not possible, the TST should be postponed for 4-6 weeks due to the fact that measles vaccination may temporarily suppress tuberculin reactivity.


**VARICELLA (CHICKEN POX):**

All employees who have close contact with persons at high risk for serious complications resulting from Varicella must provide a positive history of disease (reliable predictor), documentation of vaccination for Varicella, or laboratory evidence (reactive titer) confirming the presence of Varicella antibodies. Persons at “high risk” include; a) premature infants born to susceptible mothers, b) infants who are born at < 28 weeks of gestation or who weigh < 1,000 grams at birth (regardless of maternal immune status), c) pregnant women and d) immunocompromised persons.

Employees and students in high risk areas, who are unable to provide any of the above mentioned requirements, will be asked to comply with serological testing to determine their immune status. Serologic results will be reported to the employee or student. Those employees/students with a "non-reactive" test result will be vaccinated. The vaccination consists of two doses given 4-8 weeks apart.

**Exceptions:** Pregnancy, allergic reaction to neomycin or gelatin, reaction to previous chickenpox vaccine, immunocompromised, steroid treatment, or recipient of blood products during the past five months

(CDC. Varicella Vaccine: FAQs about Health Care Workers, National Immunization Program.)

**ANIMAL CARE EMPLOYEES:**

All employees in the Department - Lab Animal Medicine (DLAM), are required to have documentation of a current TB skin test, MMR, and Tetanus vaccine. This is a condition of employment in this specific workplace at UAMS.

**Exceptions:** Please refer to contraindications for MMR and Tetanus vaccines.

**FOOD PREPARERS:**

All employees whose duties involve the risk of directly contracting and spreading the Hepatitis A virus, specifically employees who prepare food for consumption, are required to receive the Hepatitis A vaccine. The Hepatitis A vaccine requires a booster which is recommended six to twelve months from initial immunization.

**Exceptions:** Persons who have reported an allergic reaction to previous Hepatitis A vaccine. Persons who are moderately or severely ill should wait until they recover. Hepatitis A is an inactivated virus and any risk to pregnant women, or the fetus, is thought to be very low.

**HEPATITIS B**

All employees will be offered the Hepatitis B vaccine. Generally, employees who are at increased risk for Hepatitis B infection are in locations or occupations where contact with blood from infected patients is frequent. The locations and occupations are as follows:

**LOCATIONS:**
- Blood bank
- Clinical laboratories
- Dental clinics
- Dialysis wards
- Emergency Room
- Hematology/Oncology wards
- Operating/Recovery rooms
- Pathology laboratories

**OCCUPATIONS:**
- Dentists and dental surgeons
- Dialysis technicians
- Laboratory technicians
- Nurses
- Physicians (especially surgeons and pathologists)

Hospital personnel who do not have physical exposure to blood are at no greater risk than the general population. Patient contact without physical exposure to blood has not been documented to be a risk factor.

Employees in locations or occupations listed above must have documented proof of completing the vaccine series, laboratory evidence of the presence of antibodies (reactive titer), or they will be required to obtain the three-shot series. Any employee who declines the vaccine must sign a waiver stating that they have been offered the vaccine, but choose not to receive it.

**Exceptions:** Allergic reaction to baker’s yeast or a previous Hepatitis B vaccine. Employees who are moderately or severely ill should postpone their vaccine until they recover.


**III. ADDITIONAL RECOMMENDED IMMUNIZATIONS:**

**TETANUS AND DIPHTHERIA**

Employees who have not had a primary series of tetanus and diphtheria toxoids or a booster within the past ten (10) years will be offered this immunization.

**Exceptions:** Allergic reaction to previous Tetanus or any other tetanus and diphtheria vaccine, moderate or severe illness, or pregnancy.

**INFLUENZA**

Influenza vaccine will be offered annually to all employees. An influenza vaccine log will be signed by employees.
receiving the immunization.

**Exceptions:** Allergic reaction to eggs or to a previous dose of influenza vaccine, or have a history of Guillain-Barre Syndrome.
PURPOSE

It is the goal of the University of Arkansas for Medical Sciences (UAMS) to provide the highest quality health care, education and services available. To achieve this goal it is important that administrators, faculty, staff, and students be able to fulfill their respective roles without the impairment caused by intoxication or addiction to alcohol or other drugs.

It is the policy of UAMS to provide a drug-free workplace. To support our goal of a drug-free environment, the UAMS drug testing program has been established and consist of (1) pre-employment drug testing, (2) for cause drug testing, and (3) random drug testing. (See: 3.1.14, Drug Testing)

POLICY

1. No employee or student of UAMS may report for their assignments and/or classes impaired by the use of alcohol or following the use of controlled substances.

2. Nothing in this policy will preclude the medical or research use of alcohol or controlled substances. Violators of this policy will be disciplined up to and including termination.

3. It is the underlying philosophy of UAMS that addiction to alcohol and/or other drugs represents a disease state, and treatment such problems is a legitimate part of medical practice. Employees or students with an addiction to drugs or alcohol are encouraged to seek help through the UAMS Employee Assistance Program or Student/Employee Health Service. Individuals who seek help through the UAMS EAP or Student/Employee Health Service will not be punished for seeking such help. However, appropriate disciplinary procedures linked to performance criteria are not precluded by this policy.

REFERENCE

1. UAMS 4.4.05, Drug-Free Workplace
2. UAMS 3.1.14, Drug Testing
PURPOSE

The purpose of this policy is to notify departments within the University of Arkansas for Medical Sciences (UAMS) of procedures for requesting authority to travel.

PROCEDURE (GENERAL)

Prior to traveling, a Request for Travel Authorization PR05 MUST be entered in SAP, the itinerary printed, approved (signed) by the Traveler, Supervisor, and Departmental Travel Administrator and sent to the UAMS Travel Office. The Request for Travel Authorization:

- Serves as documentation for insurance purposes
- Authorization to incur reimbursable travel expenses
- Required support document for Travel Advances
- Provides information used to file the Travel Expense Statement
- Prepayment of conference registration fees and airfare

Even if no expenses are expected, a Request for Travel Authorization should be entered and filed prior to leaving on the trip for insurance documentation. (Do not file a Request for Travel Authorization on returning from the trip unless expenses are to be claimed.)

PROCEDURE (OFFICIAL GUESTS)

(1) Official Guests of the University such as distinguished lecturers or candidates for employment are not required to obtain prior approval to travel at agency expense. A Purchase Request should be submitted instead.

(2) A “Check with Order” will be processed payable to the guest if it is submitted with proper documentation of expenditures. Proper documentation includes original commercial receipt showing payment for meals and lodging, passenger coupons for airfare, and signed written statements for mileage reimbursement for the use of private automobiles.

PROCEDURE (BLANKET TRAVEL AUTHORIZATION)

Employees who travel on a recurring basis within the State of Arkansas as a routine part of their job may obtain a Blanket Travel Authorization. A separate Request for Travel Authorization is not required for each of the trips covered by the Blanket Travel Authorization. However, such an employee should still file a Request for Travel Authorization for conferences and specific events to facilitate payment of registration fees and other items not considered in the Blanket Travel Authorization.

A new Blanket Travel Authorization must be completed and approved each fiscal year.

REFERENCES

1 UAMS Policy 8.4.03
2 UAMS Policy 8.4.05

http://uams.edu/AdminGuide/WIN08404.html
REQUEST FOR TRAVEL AUTHORIZATION INSTRUCTIONS

COMPLETING THE FORM

(1) Enter the required data in SAP.

(2) Print and sign the form.

(3) Obtain the signature of your department’s Travel Administrator. Many departments also require that this document be signed by your supervisor or department head.

(4) Submit the form with appropriate documentation such as a conference brochure, meeting announcement or explanation of the purpose of the trip to the Travel Office. The nature of the trip will determine what type of documentation is available and necessary. Be sure that the meeting dates are stated in this literature. Planned travel dates and expected expenses must be consistent with the nature and purpose of the trip.

(5) Contact the Travel Office at (501) 686-6828 if you need additional information.
The purpose of this policy is to notify departments within the University of Arkansas for Medical Sciences (UAMS) of the procedures regarding the request for and use of the Visa Corporate Card.

POLICY

UMB (Visa) and the State of Arkansas have entered into an agreement which allows state employees to apply for the Visa Individual Corporate Card. UMB reserves the right to issue or to deny issuance. UMB may consult any credit information available, including information provided by the applicant. If issuance is granted, no annual fee or interest charges (finance charges) will be assessed to the cardholder.

PROCEDURE

1. Applications for the Visa Corporate Card may be obtained by calling the Travel Office in the Finance Department at 686-6828. Applications will be sent to the employee requesting via email.

2. Charges made on the Visa Corporate Card are the personal responsibility of the cardholder, and not the responsibility of UAMS.

3. Use of these cards is subject to regulations issued by the State of Arkansas. These regulations require that the cards be used for official business travel only and that the statements be paid promptly.

4. An employee’s Visa Corporate Card will be cancelled on termination of their employment with UAMS.
Purpose

The purpose of this policy is to provide general guidelines for employees of the University of Arkansas for Medical Sciences (UAMS) who are required to travel in fulfillment of their job duties.

Policy

All travel must be consistent in fulfilling the mission of UAMS, and expenses must be incurred only as appropriate. Arkansas State law restricts the authority for travel authorization to the board or commission in charge of an agency or to the administrative head of the agency. Due to the size of the University, the Chancellor has been authorized to designate the individual in charge of a particular division or department to act as his agent in performing the duties of the Travel Administrator. Travel Administrator responsibilities include:

- Understand and follow State & University Travel Regulations
- Examine and approve all trips
- Provide written authorization/justification for items that exceed or circumvent State & University Travel Regulations
- Maintain for audit purposes a copy of all vouchers and supporting documents for travel expenses of individuals traveling on behalf of the institution
- Ensure that UAMS employees shall not approve his/her own Trip Requests

The Chancellor has also designated certain other employees to act as Travel Supervisors (The Travel Office) for the purpose of examination, approval and payment of travel expense statements.

Procedure

(1) All employees are expected to uphold the following:

a) To exercise good judgment in incurring expenses.

b) To spend the University's money as carefully and judiciously as they would their own.

c) To check for accuracy of the bills and other documents received before accepting or paying them.

d) To report all expenses promptly and accurately with the required documentation.

e) To claim reimbursement only for necessary and reasonable expenses.

(2) Information concerning all specific travel policies, procedures and regulations can be found in UAMS Administrative Guide policies 8.4.02 through 8.4.10 or http://www.campustravel.com/university/arkansasms/, click on Travel Policy.
The purpose of this policy is to notify departments and employees within the University of Arkansas for Medical Sciences (UAMS) of the procedures to be followed for requesting authorization to exceed the federal per diem rate guidelines as required in the State Travel Regulations.

Special Travel Authorization, upon approval, shall give travelers the authority to exceed the daily maximum of reimbursable expenses for costs incurred while traveling. Special Travel Authorization provides for reimbursement to the traveler for expenses exceeding the total hotel allowance as set by the Federal Per Diem rate schedule.

(1) Employees requesting authorization to exceed the Federal per diem allowance for expenses to be incurred (excluding meals) during official travel must give adequate justification on the trip entered into SAP.

(2) A Special Travel Authorization must be executed for each separate travel assignment and for each individual traveler. Final approval for special travel authorization shall be given by the Travel Administrator.

(3) Special Travel authorizations will not be issued for in-state and border area travel unless specifically provided for in the Travel Regulations. Cities such as Memphis, Tennessee, Texarkana, Texas and Greenville, Mississippi are considered border areas, and have been classified as being “within the State” for travel purposes. Special Travel authorizations cannot be approved on an “after travel” basis.

(4) The Travel Expense Statement must be submitted to the UAM Travel Office upon completion of all required recommendations and approvals.

REFERENCE

1 UAMS Policy 8.4.04
PURPOSE

The purpose of this policy is to notify students of the University of Arkansas for Medical Sciences (UAMS) and their sponsors of the UAMS regulations and procedures regarding student travel.

POLICY

It is the concern of UAMS that the University be protected from claims and liability which might arise from occasions in which students travel off campus in order to represent the University. To insure UAMS protection, the following policy and regulations apply:

The term “Official Representation” shall include student travels only when the following conditions exist:

- The student or students are authorized by a Dean, Director, Vice Chancellor or Chancellor having authority to do so, to be “official University representatives” for the purpose of attending an event related to the accomplishment of University purposes.
- The University will benefit from the representation in a substantial manner.
- The student or students travel by University vehicle or by the transportation selected and approved for them by the person authorizing their travel.
- The student or students meet campus requirements for participation in extracurricular activities.
- Before leaving the campus, the student or students, and any accompanying faculty or staff members, register according to the procedures outlined in these regulations.

NOTE: Students attending functions on their own initiative in the guise of being “from the University of Arkansas for Medical Sciences,” with the institution deriving no benefit other than that resulting publicity, are not official University representatives.

PROCEDURE (ESTABLISHING STUDENTS AS OFFICIAL REPRESENTATIVES)

(1) Due to the possibility of claims and liability arising from student travel, strict procedures must be established concerning the dispatching of enrolled students off campus for University purposes. Therefore, in order to establish students as official representatives of UAMS, the following procedure must be followed:

a) Faculty or staff sponsoring or approving the students must secure authority from the appropriate administrator of their college or division.

b) The sponsor must register the students within a reasonable amount of time in advance of the travel period by completing the University of Arkansas Notification of Off-Campus Travel of Students, available at the UAMS Web Site. The completed form must be signed by both the staff member sponsoring the student and by the division travel administrator designee. A copy of this form must be maintained in the student’s department along with other records of the travel for insurance purposes. If the student incurs any reimbursable expense his/her sponsor is responsible for submitting a purchase order for payment.

c) Many students are also employees. As a matter of simplifying documentation and reimbursement for these individuals, if a person has an employee number in SAP, his/her travel will be handled through the UAMS Travel Office the same as any other employee. However, only full-time regular employees are eligible for travel advances or the Arkansas Agency Travel Card.

It is required for an employee to file an SAP Travel Expense Statement with the Travel Department before leaving on a trip even if they expect to have no reimbursable expenses, to document that they are traveling on UAMS business and should be covered by our insurance. This also applies to student-employees and takes the place of the Notification of Off-Campus Travel of Students as documentation.

http://uams.edu/AdminGuide/WIN08408.html
The faculty sponsor must inform student representatives of the responsibilities associated with official status.

**PROCEDURE (TRAVEL REGULATIONS)**

1. The Notification of Off-Campus Travel of Students registration form must contain type of transportation being utilized. Students may travel on public carriers, in University vehicles, or by private vehicle if covered by an insurance policy currently in effect and purchased by the owner of the vehicle. If a private automobile is used, specific information regarding the owner’s insurance coverage must also be provided.

2. All applicable laws and regulations must be followed, including compliance with the UAMS Safety Program. In the event of an accident, the driver must give full disclosure of his or her name, address, vehicle registration number, driver’s license, and university state. Liability should not be admitted since all the facts may be unknown at the moment.

3. The Notification of Off-Campus Travel of Students registration form must contain type of transportation being utilized. Students may travel on public carriers, in University vehicles, or by private vehicle if covered by an insurance policy currently in effect and purchased by the owner of the vehicle. If a private automobile is used, specific information regarding the owner’s insurance coverage must also be provided.

4. Upon returning to the campus, students will file reports with their administrative office and the business manager’s office concerning any accidents, collisions, personal injuries, or property damage to themselves or to others. In the case of an accident involving a privately owned vehicle, the owner should notify his/her insurance company immediately.

5. Students are prohibited from operating University vehicles on off-campus trips as defined herein unless accompanied by a staff member.

6. When a University vehicle is to be used for off-campus travel, persons to whom vehicle possession is granted must display a valid driver’s license to Physical Plant officials. Any other passengers who may be operating the vehicle must also present a valid driver’s license.

7. The above rules are inapplicable in the following situations:
   a) Riding in University-operated vehicles between portions of campus located in the same city or its suburbs.
   b) Riding during off-campus trips organized in their own interest. Such trips are not made as official travel on behalf of UAMS, and the University bears no responsibility for any liability arising therefrom.
   c) Dispatching of a student on an errand in a city where he/she is regularly enrolled.

**PROCEDURE (SPONSORS)**

8. All groups must have a sponsor on an official trip in order to insure the University against public criticism. Individual sponsors accompanying students on off-campus trips assume responsibility concerning the safety of students, their conduct, and for the overall representation of the university. Sponsors may become liable for any person or persons injured, if the injury is a result of the sponsor’s negligence. In addition, any actions of the sponsor that occur as a result of something within the sponsor’s general authority may reflect on the University. As a University employee, the sponsor is obligated to maintain reasonable order.

**PROCEDURE (STUDENT CONDUCT)**

9. Students away from the campus as University representatives are subject to disciplinary action by the University for breaches of conduct. The accompanying sponsor is authorized to maintain good order and good representation during the trip. Students returning to the campus may receive disciplinary action for their misconduct during the trip.

**PROCEDURE (TRAVEL REGULATIONS)**

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**UNIVERSITY OF ARKANSAS**

**NOTIFICATION OF OFF-CAMPUS TRAVEL OF STUDENTS**

1. IDENTIFICATION

   a) Name of group: ________________________________
   b) Purpose of trip: ________________________________
   c) Expected absence from campus: From ___________ AM/PM ___________, 20___;
   To ______________ AM/PM __________________________, 20____

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II. ITINERARY: (Please list those points at which members of the group can be reached in case of an emergency. Continue on back if necessary.)

Address (City, Hotel, Institution, Etc.)
Dates and Hours

III. MEMBERS OF GROUP: (Please type names and colleges of students and faculty who are expected make the trip. Designate faculty by placing an “(f)” after the names of faculty members. (Continue on back if necessary.)

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IV. SIGNATURE OF SPONSOR: ____________________________ Date: __________

V. __________________________________________ Date: __________

DIVISION TRAVEL OR DESIGNEE SIGNATURE


http://uams.edu/AdminGuide/WIN08408.html
PURPOSE

The purpose of this policy is to notify departments within the University of Arkansas for Medical Sciences (UAMS) of the procedure for requesting advance payment for anticipated expenses to be incurred while traveling on official state business.

POLICY

Due to the availability of the Arkansas Agency Travel Card (also known as the VISA Corporate Card), travel advance payments are generally no longer necessary. However, Travel Advance Requests may be warranted for employees who have not applied for or received an Arkansas Agency Travel Card; for employees lodging where the Arkansas Agency Travel Card is not accepted; or for the employees traveling to a foreign country.

PROCEDURE

(1) Employees requesting advance payment for expenses to be incurred while traveling on official state business must complete and submit a Request for Travel Advance form to the Travel Office for approval and processing. This form is to be submitted with the employee’s Request for Travel Authorization.

(2) Request for Travel Advance forms must be submitted to the Travel Office no later than five working days prior to scheduled departure.

(3) Upon approval of Request for Travel Advance, checks will available for pickup in the Treasurer’s Office no earlier than two days prior to the scheduled departure.

(4) Advance payment for anticipated expenses shall be considered a loan to the individual, as is clearly stated on the Request for Travel Advance form. In signing for the funds on the bottom of the Request for Travel Advance form, the individual agrees to pay back the advance on a timely basis.

(5) Employees failing to reimburse UAMS for travel advance payments within 5 days after returning to work may be subject to a withholding from their paycheck.

(6) Obtaining a Travel Advance does not relieve the traveler from filing a Travel Expense Reimbursement Request in SAP upon completion of travel.

(7) Travel Advances are computed at the rate of 50% of the total anticipated travel expenses that have not been prepaid by UAMS in the following categories:
   a) Meals
   b) Lodging
   c) Anticipated taxi fares

REFERENCES

1 UAMS Procedure 8.4.02, Credit Cards
2 UAMS Procedure 8.4.05, Travel Expense Reimbursement
REQUEST FOR TRAVEL ADVANCE

Applicant______________            Date  _________________________

Department  ___________________________________    Fund & Fund Center _________________________

Telephone __________________ Travel Dates: From __________________ To _________________________

I am requesting approval to travel to ____________________________________________________________

and return. If approval is granted, I request a travel advance equal to 50% of the eligible expenses.

_____ My trip will require me to be in travel status for 72 consecutive hours or more: or

_____ My request is based on hardship as cited below:
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Applicant___________________________________________  Date____________________________

(Requesting Employee’s Signature)

Approval Recommended ____________________________  Date  ______________________________

(Tavel Administrator)

Approved_________________________________________  Date____________________________

(Controller)

Days at $________________ = $___________________  Trip#  ____________________

Check# ___________________ Date _______________________  Issued by ____________________

I, ______________________________________
[0x0], an employee of the University of Arkansas for Medical Sciences, acknowledge that I have applied for and received from
the UAMS Treasurer a travel advance as shown above to be used for the payment of expenses in connection with official travel to be performed by me. This advance
represents a loan by UAMS to me to be used only for this purpose.

I agree that this amount is to be repaid to the Treasurer from the travel reimbursement amount which would otherwise be paid me, pursuant to the above authorization upon
my return from this trip, and the execution of this form is intended to be an assignment by me of that reimbursable amount to the extent of the travel advance set out above.

I also agree that my reimbursement claim showing expenses incurred will be filed with the Travel Office within five (5) working days after completion of this travel.

In consideration of the receipt by me of these funds in advance of the expenditure thereof, I agree that (1) in the event that I fail to file a reimbursement claim and show the
expenditures thereon which I actually incurred and/or (2) in the event I do not expend all of said advance for official travel on behalf of UAMS, then in either of these events
UAMS may reimburse itself by withholding an equivalent amount from my subsequent payroll checks, or from other amounts which may be payable to me by the University.

Employee Signature                         Date
REQUEST FOR TRAVEL ADVANCE INSTRUCTIONS

GENERAL INFORMATION

The Request for Travel Advance must be completed and forwarded to the Travel Office for approval and processing. Submit this form with the Request for Travel Authorization. If the Travel Advance is approved the applicant must sign the lower portion of the form in the Treasurer’s Office.

COMPLETING THE FORM

1) Applicant: Enter the name of the person requesting the travel advance.

2) Date: Enter the date that this request is made.

3) Department: Enter the name of the department initiating the request.

4) Fund & Fund Center: Enter the Fund and Fund Center to be charged for the expenses.

5) Telephone: Enter the telephone number of the person initiating the request.

6) Travel Dates: From/To: Enter the date on which the travel period is to begin and the date on which the travel is to end.

7) Travel to: Identify the city to which the employee will be traveling.

8) 72 Hours/Hardship: Check the appropriate space determining sufficient reason for making a Travel Advance Request. If the reason is due to hardship, include a brief statement of explanation. If the traveler holds an Arkansas Agency Travel Card, state the reason(s) why a Travel Advance is necessary.

9) Applicant/Date: Enter the signature of the requesting employee and the date signed.

10) Approval Recommended: Obtain the signature of your Department’s Travel Administrator before forwarding to the Travel Office.
The purpose of this policy is to notify departments within the University of Arkansas for Medical Sciences (UAMS) of the procedures to be followed in requesting reimbursement of costs incurred by UAMS employees during official travel.

**POLICY**

Reimbursement for travel expenses will be made only for those items of actual expense incurred in connection with the official duties of the traveler, and within the limits and restrictions of Arkansas State law and UAMS guidelines.

An employee may not be reimbursed for any travel expenses prior to travel occurring except in cases where it is pre-approved by the UAMS Travel Office. Adequate justification and documentation showing the prior approval of their department chair or dean must be submitted to the Travel Office with the trip request.

Reimbursements cannot be requested beyond one year from the ending date of the trip.

A travel reimbursement(s) cannot be requested after cessation of employment, unless trip was entered and approved in SAP prior to termination.

**PROCEDURE**

1. Employees requesting reimbursement for expenses incurred for official travel and related expenses must complete a Travel Expense Statement in SAP within 30 calendar days from the end of the trip. When a trip occurs at fiscal year end, and/or transcends both fiscal years, the Travel Expense Statement form should be filed immediately upon return from the trip so the expenses will post in the correct accounting periods.

2. The completed Travel Expense Statement must be submitted with appropriate documentation to the Travel Office, Slot # 545, for audit and payment.

3. Travelers must obtain hotel lodging receipts and commercial transportation receipts. All required, original receipts must be attached to the form upon submittal to the Travel Office.

4. Each state employee incurring travel expenses is required to file an individual Travel Expense Statement. Each traveler must report only his/her own expenses on the Travel Expense Statement form and is prohibited from including the meals or lodging on behalf of any other person.

5. The reimbursement rate for mileage in private automobiles used for official travel is set by the State Department of Finance and Administration. The current rate may be found at the State of Arkansas Website under Department of Finance and Administration, Office of State Procurement, Travel Regulations. Reimbursement is limited to the lesser of coach class airfare or the mileage rate allowed for private car travel.

6. Meals are reimbursed for out-of-state travel, international travel and for overnight travel within the State of Arkansas. The current reimbursement rate for meals is the Federal Per Diem Rate, which may be found at www.policyworks.gov. Follow the travel links to the domestic per diem rates. **Note: Reimbursement should be requested for the actual cost NOT to exceed this per diem.**

7. Reimbursement for lodging is normally limited to the single room rate. Anything other than the single room rate must be justified. Employees sharing a room should claim one-half of the nightly room rental rate and taxes on their respective Statement of Travel
8. Actual lodging charges are reimbursed upon presentation of an original commercial lodging receipt attached to the Travel Expense Statement form. The original commercial lodging receipt should show dates of occupancy and the name and address of the place of lodging. Copies of lodging receipts are acceptable only to document more than one person occupying the same room.

9. Reimbursement claims for partial days of travel (during which all four allotted items including breakfast, lunch, dinner and lodging, are not included in the claim), must be reasonable and proportional to amounts claimed for the same items claimed for an entire day. Travelers must be aware that reimbursement is to be claimed for actual expenses for meals and lodging within the limitations set forth herein, and the maximum must not be claimed unless expenditures for such purposes are actually made.

1. (15%) Breakfast may be claimed if the employee leaves their official station prior to 6:30 am.

2. (35%) Lunch may be claimed if the employee leaves their official station prior to 11:30 am, and when returning to home station if he/she arrives after 12:30 pm.

3. (50%) Dinner may be claimed if the employee leaves their official station prior to 5:00 pm; and when returning, they arrive after 6:30 pm.

10. In addition to review in the UAMS Travel Office, travel expenses are subject to audit by the State Legislative Audit, UA System Internal Audit and others as needed.

11. Departments should seek and utilize discounted airfare rates whenever possible. Reimbursement is limited to the lesser of coach class or the mileage rate allowed for private car travel. If the airfare itinerary reflects first class fare, explanation of usage must be described and/or documented prior to reimbursement or payment.

12. In addition to the reimbursement for meals and lodging allowed for the total number of days during domestic travel activities by commercial air, travelers may also be allowed reimbursement for meals and lodging for one day prior to the scheduled beginning date of activity, and one day following the ending date of activity, depending upon time of arrival, etc. This additional reimbursement is subject to approval of the UAMS Travel Manager.

13. Departments may make air travel reservations with the airline or travel agency of their choice. However, certain travel agencies have agreed to provide services to UAMS at special rates. Information concerning these agencies may be found at the UAMS website under www.uams.edu/finance/travel.

14. Employees who are driving are permitted travel time of one day for each 450 miles driving both to and from the event. For example, if the one way distance from Little Rock to the destination is 600 miles, a total of four days travel time would be allowed.

15. When two or more employees travel on official business in the same personal motor vehicle, reimbursement shall be limited to the owner of the vehicle only. UAMS has no responsibility whatsoever for any maintenance, operational costs, accidents, fines, tolls, insurance, etc., incurred by the owner of any personal vehicle used while on official business. Reimbursement for business use of personal vehicles is limited to the mileage rate discussed above.

16. All applicable laws and regulations must be followed in the operation of any vehicle on official business, including compliance with the UAMS Safety Program.

17. Travelers requesting the use of a University owned vehicle must submit a requisition to the Physical Plant Department accompanied by an approved Travel Authorization.

18. Emergency repairs to University vehicles are reimbursable. An original itemized invoice and a commercial receipt are required for reimbursement.

19. Justification for use of a rental car must be made and approved on the Travel Authorization (TA). For example, if an employee is not staying at the conference site hotel due to lodging costs, and the cost of a rental vehicle, including parking, is less than the difference in lodging cost, the cost would be economically justified. If prior approval has not been obtained on the TA, an explanation of the need for the rental vehicle must be given on the Travel Expense Statement and is subject to the approval of the UAMS Travel Manager before any reimbursement can be made.

20. Reimbursement for use of privately owned aircraft may be authorized. At the date of this policy, the rate is .45 per nautical mile. The current rate may be found at the State of Arkansas Website under Department of Finance and Administration, Office of State Procurement, Travel Regulations.

21. Registration fees for conferences, conventions, and seminars may be paid in advance through SAP Travel or the use of the Departmental BTA(VISA). However, if one must register on-site, reimbursement shall be permitted when accompanied by the
"official" statement of the registration fees and an original commercial receipt showing payment.

22. Parking fees shall be reimbursable when accompanied by an original commercial receipt.

23. Taxi fares shall be reimbursable. Employees should obtain a receipt when possible.

24. Telephone calls shall be reimbursable when made for business purposes and are certified as business calls by the traveler.

25. Reimbursement shall not be allowed for personal entertainment, alcoholic beverages, tips, valet services, flowers, laundry or cleaning. However, incidental expenses directly related to the business purpose of the trip may be allowed with proper documentation and approval. Arkansas State Statute does not allow for reimbursement of tips or gratuities.

26. Reimbursement shall not be allowed to any traveler for meals or lodging within the traveler's "Official Duty Station."

27. Where available, and where accepted by the travel vendor (hotel, airline, travel agent, conference sponsor, etc.) hotel registration, airfare, and conference or seminar registration fees may be charged to a departmental Business Travel Account (BTA).

28. Direct billing for lodging shall not be permitted in general; however, special circumstances sometimes warrant the use of this procedure. Contact the Travel Office to obtain approval for direct billing.

REFERENCE
¹UAMS Policy 8.4.01  ²UAMS Policy 8.4.04  ³UAMS Policy 8.4.02
The purpose of this policy is to establish a procedure to enable UAMS departments to purchase airline tickets and other approved travel items through various travel agencies and the UAMS Travel website. UAMS participates in the State of Arkansas sponsored Business Travel Account program. Using a BTA allows a department to charge expenses for official business travel (airfare, hotel & conference registration fees) and make payment on a monthly statement.

### Procedure

**How to Establish the Account:**

Interested UAMS Departments should complete the Visa BTA Information Form, which can be obtained from the Travel Office in the Finance Department by calling 501-686-6828. The form will be sent to you by email. Once approved, you will not receive a credit card, just an account number.

Some departments and colleges at UAMS have additional policies relating to the establishment of a BTA.

**Using the BTA:**

The UMB Visa BTA account may be used to:

- Book and pay for **airfare**
- Reserve and sometimes pay for **lodging**
- Secure and pay for **registration fees** when the following rules are followed

**Airfare:** Upon making flight reservations and using the VISA BTA account to charge airfare, only regular coach airfare can be purchased. Information that the BTA was used must be entered in the Comments section of the trip details in SAP. The expense type to be used is CCPO (Common Carrier Paid Out/In State). This will allow a payment directly to VISA. Failure to use this correct expense type could result in the traveler being reimbursed for this charge causing the Statement charges to be delinquent. The VISA Statement should be reviewed immediately upon receipt by the department and sent to the Travel Office for payment. Each individual charge must reference the personnel number. Also, attach the airfare itinerary to the Statement.

**Lodging:** When using the BTA to reserve lodging for an employee, the comments in the SAP trip details must be noted because there is a possibility that a deposit may be charged to the account. Some sources of lodging will allow the BTA to cover all nights, where some will only hold the reservation and the traveler must present a personal credit card upon check-in and check-out. These charges will then be reimbursed to the traveler. Only the room rate plus room taxes may be charged to a BTA. Other costs such as meals, phone calls, parking, movies, etc. must be paid by the traveler. These costs cannot be paid directly to VISA by the Travel Office. Failure to follow this could result in the account being delinquent. All charges related to lodging on a BTA statement must reference the personnel number and trip number for the traveler. Documentation must be attached to the statement to support the charges, such as the Original hotel bill, confirmation charge for a deposit, etc.

**Registration Fees:** The BTA may be used to secure and pay for conference registration fees. This is for **registration fees only**: optional or social events may not be paid for without prior approval from the UAMS Travel Office. Fees that are not allowed will not be paid by the UAMS Travel Office and can result in delinquency of the account. Upon presenting the BTA statement for payment, each charge must have the trip number noted and documentation to support the charges, such as a copy of the registration for or invoice.
PURPOSE

The purpose of this policy is to provide employees and students of the University of Arkansas for Medical Sciences (UAMS) with information regarding travel insurance coverage during periods in which they are traveling in official travel status.

POLICY

Full time employees on official travel status are covered by $25,000 of accident insurance with regard to loss of life, dismemberment, or total disability, excluding travel by privately owned aircraft or acting as a pilot, operator or member of a flight crew.

PROCEDURE (CAR RENTAL INSURANCE)

The University does maintain insurance for vehicles rented by employees on University business. It provides a $1,000,000 limit of liability for bodily injury and property damage claims. It also provides uninsured motorist coverage at the same limit and medical coverage up to $5,000 per person.

The University's policy will be in effect only during the period of official business. Should the employee elect to keep the rental vehicle for personal use after the end of official business, he/she would need to provide additional coverage.

PROCEDURE (EMPLOYEES)

1. To ensure insurance coverage, employees must submit a Request for Authorization of Travel Expenses to the Office of Financial Services prior to travel.
2. Employees temporarily incapacitated through accidental injuries during travel on official University business shall be treated as having on-the-job injuries for salary and medical benefits purposes.

PROCEDURE (STUDENTS)

3. In order to insure adequate protection for students, and to insure that UAMS is protected from claims and liability arising from such occasions, students must follow the guidelines listed in the Student Travel Regulations.

REFERENCE

1 UAMS Policy 8.4.04
2 UAMS Policy 8.4.08
How to Reconcile/Pay the BTA:

_It is critically important that the BTA statement be paid on time._ Delinquent accounts will be closed by UMB as directed by the Department of Finance and Administration. It is difficult for us to get these accounts reopened.

The department will receive a monthly statement from VISA, mailed directly to the departmental contact person, detailing individual tickets purchased by traveler, destination, date, and amount. The contact person should write the trip number for each traveler on the statement, sign it as authorizing for payment, and forward it to the Travel Office in the Finance Department with necessary documentation, such as airfare and hotel receipts.

UAMS Travel Regulations are still in affect, and individual travel reimbursement requests will be handled through the SAP Travel Module for employees and Procurement for non-employees. Some departments and colleges at UAMS may have additional policies pertaining to travel by their employees.

Questions concerning any of the above issues should be directed to the UAMS Travel Office at 501-686-6828.
The purpose of this policy is to establish guidelines for the issue and return of Official UAMS ID badges and to inform departments within UAMS of the policies regarding official ID badges.

Official identification badges are considered by UAMS to be vital to campus security, to be critical to many administrative processes, and to be of informational value to patients and visitors. It is therefore policy that all UAMS students, faculty, staff and certain other authorized persons are issued official UAMS identification badges and are expected to wear them while on UAMS premises and follow all other procedures relating to proper use and care of ID badges.

PROCEDURES

1. Authority and issuance

   a. Students: Badges for students are authorized by the college in which the student is enrolled. Initial badges are issued free of charge to the individual. Student badges are valid for one year from date of issue, as indicated by the validation sticker affixed to the badge. Badges may be re-validated by the college for additional one-year periods as necessary with the issuance of a current validation sticker.

   b. Faculty and Staff: The UAMS Office of Human Resources authorizes badges for faculty and staff based upon entry of employee information into the UAMS personnel information system by the employee’s department. Badges will be issued to faculty and staff only after the department has entered required employee information into the UAMS personnel information system. Entry of this information is deemed to be departmental authorization for issuance of a UAMS ID badge. Exceptions to this practice may be made on an individual basis. Such exceptions must be documented and authorized in writing by the director or higher official of the requesting unit.

       Initial badges are issued to the individual at university expense. Faculty and staff badges are issued with no specific expiration date.

   c. Others: Visiting faculty and employees of other agencies or contracted companies who are based on the UAMS campus must also obtain an ID badge so that:
      
      - Patients and other staff are assured that they are authorized to perform their tasks.
      - They can obtain computer, library, and other privileges necessary to their work.
      - They can enter certain restricted areas.
      - They can receive cafeteria and other appropriate discounts.

       Construction contractors working at UAMS will be required to wear appropriate identification. Company issued ID, with name of employee and company conspicuously displayed, will suffice for new construction projects where contractors will not enter existing facilities. For renovation projects in existing facilities contractors will be required to wear a UAMS issued ID badge. It is understood that contractors will occasionally enter dining or other UAMS facilities when working new facilities and this infrequent entry will not require issue of a UAMS issued ID.
The UAMS Office of Human Resources authorizes badges for visiting faculty, contractors, employees of other agencies, and other non-employees based upon entry of information into the UAMS personnel information system by the sponsoring departments. The sponsoring department authorizes the issuance of a badge to a non-employee and a badge will be issued only after the department has entered required non-employee information into the UAMS personnel information system. Entry of this information is deemed to be departmental authorization for issuance of a UAMS ID badge. Exceptions to this practice may be made on a case-by-case basis. Such exceptions must be documented and authorized in writing by the director or higher official of the sponsoring department.

The sponsoring department will be charged for the initial issue of the badge. (See Administrative Guide policies on "Non-Employees" and "Visiting Faculty").

d. Issuance: All badges are issued by UAMS Media Services.

2. Ownership and surrender

   a. UAMS ID Badges are the property of the University of Arkansas for Medical Sciences. They must be surrendered upon request by UAMS officials, upon termination of employment, upon termination of student status, or upon expiration of "sponsorship" of visiting faculty, contractors, or employees of other agencies.

   b. The management and return of student ID badges falls under the purview of the college in which the student is enrolled. Badges returned to the college by a student will be turned over to the UAMS Police Department.

   c. The management and return of faculty, staff and other ID badges falls under the purview of the sponsoring department or the department or college in which the individual is employed. Terminating individuals should be advised by their department or college to turn in their ID badge at the UAMS Police Department according to campus clearance procedures. Badges turned in to a college or department will be turned over to the UAMS Police Department.

3. Replacement

   a. Official change in employee status: Replacement badges due to promotion, transfer or other official change in status will be provided to the employee at university expense.

   b. Personal change in employee or student status: Replacement badges due to marriage, divorce, voluntary name change or other personal changes in status will be the responsibility of, and will be charged to, the individual.

   c. Loss or theft: Replacement badges due to loss, theft or damage will be the responsibility of, and will be charged to, the individual.

   d. Others: Replacement badges for visiting faculty, contractors, or employees of other agencies will be charged to the "sponsoring department."

   e. Badges reported lost will be rendered inactive and a replacement badge will be issued. Activation of certain functions of lost badge replacements may require up to 24 hours.

   f. It has been determined that typical life expectancy of ID badges under normal conditions of use is four years. A new badge will be provided on request at university expense to replace a badge that is at least four years old.

4. Issuance of multiple badges

   a. Automated timekeeping systems for which UAMS ID badges are used to clock in and clock out may require that non-exempt employees who hold two (concurrent) positions have an ID badge for each position. Such employees who clock in and clock out in either position will be issued a separate badge for the second position. The second badge will be marked "ALT" as alternate, so the employee is able to distinguish between the primary and the alternate position.

5. Care and safekeeping

   a. UAMS badge holders are expected to exercise ordinary care in the use and safekeeping of UAMS ID badges. Some guidelines for best practices are:

      • Protect the badge from magnetic fields that could scramble the data encoded on the badge’s magnetic stripe.
      • Avoid extreme heat which may cause the badge to come apart (example – don’t leave a badge on the dashboard of a car in hot weather).
      • Avoid excessive moisture which may also cause the badge to disassemble (example – be sure to remove...
the badge from clothing before laundering).

- Treat the badge as you would house, work, or car keys – always keep it in a safe place when it’s not being worn.

6. Falsification, alteration, tampering

   a. Any falsification, alteration or tampering with an official UAMS ID badge is against UAMS policy and may be cause for disciplinary action including the possibility of immediate termination.
UNIVERSITYWIDE ADMINISTRATIVE MEMORANDUM

USE OF UNIVERSITY FACILITIES

I. Statement of Principles

The University of Arkansas has an obligation to its students and to the larger society of which it is a part to provide the fullest opportunity for a free exchange and critical evaluation of diverse viewpoints. This means freedom to teach, freedom to learn, freedom to discuss, and freedom to expose ideas to the critical analysis appropriate to the University setting. In order to accomplish this mission, the administration, faculty, and students have a continuing responsibility for preserving the properly directed use of the institution’s freedom to teach, to discuss, and to explore.

The University’s dedication to the spirit of free inquiry requires the examination and evaluation of controversial viewpoints, but obviously does not require the endorsement of such viewpoints. Divergent points of view must be recognized, but at the same time kept within a framework of orderly conduct in accordance with human dignity, respect for the individual, and the responsibilities of the University. The University is not available for exploitation, and special interests out of harmony with its educational objectives are not to be served.

II. Policy Statement of the Board of Trustees

University facilities exist for the primary purpose of serving a planned and scheduled program of educational activity. At times when not required in the regularly planned educational program, University facilities may be made available for extracurricular use to college, departments, and other organizational units of the University; to organizations composed exclusively of faculty and staff; to organizations which exist solely for the benefit of the University; and to recognized student organizations with the approval of the faculty advisor.

University facilities under the law cannot be made available to other organizations for their own purposes. However, when a facility is in use neither for a regularly scheduled educational activity nor for an extracurricular use by one of the University organizations listed above, the President or Chancellor is authorized to approve the use of the facility when such use serves the educational objectives of the University. It is an objective of the University to provide opportunities for University and broader communities to see and hear major leaders from throughout the state, nation, and world. Speeches and debates by or on behalf of candidates for major state or national offices may be scheduled in University facilities under arrangements which allow reasonable opportunities for opposing candidates or points of view. It must be made clear that the University neither supports nor opposes the views stated by and/or the candidacy of such individuals.
III. Procedures

A. Faculty and Staff

A member of the faculty shall be free to invite outside speakers to participate in any class, conference, or institute which is a part of the University educational program.

Any college, department or other organization of the faculty or administration, any organization composed exclusively of faculty members or University employees and any other organization whose membership includes University faculty members and which exists solely for the benefit of the University or for scholarly pursuits may use University facilities to hold meetings, subject only to local regulations regarding room scheduling.

B. Student Organizations

Any recognized student organization may use University facilities for open or closed meetings or performances subject only to local campus scheduling regulations.

If an off-campus speaker or performer is to be invited to address an open meeting of a recognized student organization, the faculty advisor must give his or her approval prior to the time that an invitation is extended and publicity is released. In the event that the group does not currently have an official advisor, the approval of a faculty member or administrator is required. The University administration may properly inform an organization concerning its views on any proposed meeting to which an off-campus speaker or performer has been invited but will leave the final decision concerning the meeting to the organization and its advisor.

Publicity and communications concerning any meetings shall clearly identify the sponsoring organization and shall carefully avoid any stated or implied University sponsorship. In all open meetings at which an off-campus speaker will speak, a faculty member or administrator shall be present and a reasonable period shall be reserved for questions from the audience.

An invitation to a speaker does not necessarily imply approval or disapproval of the speaker or his or her views by either the University or the student organization. In case a request for the use of a University facility by a recognized student organization cannot be granted, it is the responsibility of the University officer to whom the request was made to notify promptly the writing the organization making the request stating the reasons for the denial.
Speakers may be invited to the campus to discuss political issues. Recognized student organizations may solicit membership and dues at meetings. However, money may not be raised for projects not directly connected with a University activity, and private business may not be conducted in University facilities.

C. Non-University Groups

The facilities and resources of the University exist for the sole purpose of supporting and furthering a program of higher learning. The use of facilities of the University should be extended to non-University groups only when that use will enhance, support, further, or enrich the educational program of the University and such use will not interfere with the educational activities of the University.

Requests for the use of University facilities by a non-University group should be directed to an individual designated by the Chancellor. The evaluation of the appropriateness and worth to the University program of a particular use of facilities by a non-University group or organization shall be based upon the following criteria:

1) Relevance and contribution to the needs of the educational program of the University.

2) Timeliness and intrinsic merit of the activity.

3) Availability of suitable space not needed for the educational activities of the University.

University facilities shall not be used by non-University groups or organizations for their own exclusive purposes, for the raising of money for projects not directly connected with a University activity, or for the conduct of private business.

November 19, 1999 (Revised)
November 3, 1978 (Revised)
August 12, 1976 (Revised)
July 15, 1976
UNIVERSITYWIDE ADMINISTRATIVE MEMORANDUM 720.1

ROOFS AND EXTERIOR WALLS OF BUILDINGS, USE OF

The University has a concern about improper uses of roofs and its buildings and uses of exterior sides of buildings reached by way of roofs or upper windows. Such portions of buildings are not intended for general traffic, personal injuries and damages to roofs and buildings may result.

The following regulations regarding such sites are to be enforced by University personnel having charge of a building or buildings, and by the security officers of the institution:

1. The areas described shall be accessible to University employees, such as Physical Plant personnel, having a need directly associated with their work on behalf of the University. They are to be accessible for members of the faculty and their students in connection with a regularly-scheduled curriculum course which requires such access (e.g., Astronomy class, Electrical Engineering Antennae Laboratory, etc.), but only after establishing with the Director of the Physical Plant those areas which may be utilized without damage to roof or structure and in order that proper grounding of lightning hazards may be installed on any equipment erected.

2. Other than those University employees and students specified above, any other persons (including students, employees, or those not associated with the University) found in or on the areas described above shall be removed therefrom and arrested for trespassing and/or charged with violation of institutional regulations (subjected to University disciplinary proceedings). It is the duty of University employees to report such violators. Action should also be taken to again secure the points of access used by such violators.

3. Where there is legitimate need for non-University personnel (architects, independent contractors installing or repairing facilities, etc.) to be permitted access to the areas described, their requests should be referred to the Director of the Physical Plant. He shall supervise, and may condition, the access in order to protect the interests of the University in the event he grants the permission. Permission shall be granted subject to execution of the attached release form.

4. No rooftop machinery, equipment, antennae, greenhouses, rappelling anchors (temporary or permanent), or other property shall be installed on roofs or roof edges without express permission from the Director of Physical Plant for the particular campus.

5. Rappelling using University buildings is specifically prohibited.

6. Student handbooks shall contain a summary of this policy, as shall faculty and staff handbooks. University security officers shall enforce this policy.

Form attached.

October 4, 1982
RELEASE

In consideration of the permission granted to me to go upon the roof area, including overhanging areas outside of windows, at a University of Arkansas building on the campus, for the purpose of doing the following acts:

which acts, it is agreed, are for my own interest and benefit, I do hereby release and forever discharge the said University of Arkansas, its agents and employees, from any and all actions, causes of action, claims and demands for, upon, or by reason of any damage, loss, injury or death, either to my person or to my property, which may be sustained by reason of this entry upon and in the property of the University of Arkansas, intending hereby to release any and all such claims which I, or my heirs, and/or personal representatives can, shall or may have, by reason of any such damage, loss, injury or death.

And, further, I covenant and agree to protect and save harmless said University of Arkansas and all of its employees, from any loss, damage or expense, by reason of litigation or otherwise, on account of any such claim, asserted liability, injury or death to person or property as aforesaid.

Further, I agree to repair, restore and make good any damage which I or my property shall cause or do while in and on said University property, and will take reasonable precautions to see that roof exits are closed and secured when I shall have completed the said described entry.

THIS IS A RELEASE — READ CAREFULLY BEFORE SIGNING.

___________________________________________
Date:

Witnesses:

___________________________________________
___________________________________________

Prepare in Duplicate:
1. Copy for applicant
2. Copy for Director of Physical Plant
Healthcare workers face a significant risk of job-related violence. The following policy provides a means of addressing workplace violence.

**POLICY**

The safety and security of personnel, patients and visitors is of vital importance. Acts or threats of physical violence, including intimidation, harassment or coercion, which occur on UAMS property will not be tolerated.

This prohibition against threats and acts of violence applies to all persons involved, including but not limited to UAMS personnel, contract and temporary personnel, patients and visitors. A violation of this policy by any individual on UAMS property is considered gross misconduct and will lead to disciplinary and/or legal action.

No reprisals will be taken against any employee who reports or experiences workplace violence.

**PROCEDURE**

A. **ACTIVATION**

**LEVEL I Workplace Violence**-Attempted or threatened conduct of a person that is likely to endanger the health and safety of a UAMS employee patient or visitor. This includes threatening statements, harassment, or other behavior that gives an employee patient or visitor reasonable cause to believe that their health and safety is at risk.

1. **Campus Personnel:** Personnel shall immediately report any LEVEL I acts or threats of violence occurring on UAMS property to their supervisor.

2. **Supervisors/Managers:** The responsible manager shall respond to the area, and attempt to deescalate the situation. If necessary, they will call UAMS Police at 686-7777 or local police authorities in areas not served by UAMS Police for assistance. When employees are involved, disciplinary action may be taken as appropriate and in accordance with the (Administrative Policy 4.4.02)\(^1\). When patients are involved in acts of violence toward staff, the responsible CSM or Clinical Service Manager notifies UAMS Risk Management for disposition/resolution.

**Level II Workplace Violence**-Physical violence of any type, including pushing shoving or other conduct of a person that is likely to endanger the health and safety of a UAMS employee patient or visitor.

1. **Campus Personnel:** Personnel shall immediately report any LEVEL II acts of violence occurring on UAMS property to their supervisor and UAMS Police Department by calling 686-7777 or local police authorities as appropriate.
2. **UAMS Police:** The UAMS Police or local police authorities for areas not served by UAMS Police, shall immediately respond to the area, and deescalate the situation.

3. **Supervisors/Managers:** When employees are involved, disciplinary action may be taken as appropriate and in accordance with Administrative Policy 4.4.02.

**B. RESPONSIBILITY**

1. **All UAMS Personnel:** UAMS personnel must refrain from engaging in acts of violence and are responsible for maintaining a work environment free from acts or threats of violence. All employees shall be held accountable for reporting incidents of violence through appropriate channels.

2. **UAMS Safety Committee:** The UAMS Safety Coordinating Committee is responsible for the overall implementation and maintenance of the Campus’ Workplace Violence Prevention Plan. Safety Committee members include representatives from the following departments: Occupational Health and Safety, Physical Plant, Radiology, Pathology, Nursing, Emergency Medicine, UAMS Police, CHRP, College of Nursing, College of Pharmacy, Psychiatry, Outpatient Services and College of Medicine.

3. **Duties of the Safety Committee** include, but are not limited to, improving the Campus’ readiness to address workplace violence by:
   a) Reviewing past incidents of violence on the UAMS campus.
   b) Reviewing Campus readiness to respond to issues of workplace violence.
   c) Developing an expertise among appropriate members of management regarding issues of workplace violence.
   d) Establishing liaison with local law enforcement and emergency services.
   e) Training UAMS personnel.
   f) The Safety Committee may assign all or some of these tasks to other UAMS employees. The Safety Committee remains ultimately responsible for implementing and maintenance of the Campus Workplace Violence Prevention Plan.

4. **Managers and Supervisors:** Managers are responsible for the following
   a) Workplace violence prevention training for personnel under their supervision. Training may be scheduled by contacting UAMS Police or Staff Education.
   b) Managers and supervisors are encouraged to report all incidents of violence, and to follow-up on violence related incidents, including completion of disciplinary action for involved employees when appropriate.
   c) Contract services personnel working on UAMS premises shall be informed of Workplace Violence Prevention requirements by contracting department prior to doing any actual work on UAMS premises.

**C. PREVENTION PROGRAM FOR WORKPLACE SECURITY**

1. The UAMS prevention program for workplace security includes the following:
   a) Regular security and safety assessments of the UAMS campus;
   b) Certified Police Officers to provide security;
c) Adequate security systems including door locks, security windows, physical barriers and restraint systems;

d) Employee training;

e) Effective systems to warn others of a security danger or to summon assistance (i.e., panic buttons).

D. MEDICAL MANAGEMENT

Employees, patients and visitors who have been victims of workplace violence should be referred to the appropriate source for medical care when needed. Employees may receive immediate physical evaluations and treatment for acute injuries in accordance with UAMS Administrative Policy 11.4.01. Referrals may be made for appropriate evaluation, treatment, counseling and assistance both at the time of the incident and for any follow-up treatment necessary at the discretion of the supervisor/manger.

E. RECORDKEEPING

Recordkeeping is used to provide information for analysis; evaluation of methods of control, severity determinations, and training needs and program evaluations.

1. Recordkeeping may include any or all of the following:

a) Completion of the UAMS Uniform Police Report for all incidents including:

   1. All incidents of abuse, verbal attacks or aggressive behavior;

   2. All incidents resulting in injury;

b) Completion of the UAMS Incident and Injury Report form (Administrative Policy 11.4.01)\(^2\) for all incidents involving an employee, a student or a visitor including:

   1. All incidents resulting in injury;

c) Completion of the Confidential Variance Report form (Hospital Policy ML.1.04)\(^3\), or other variance form as appropriate to your department, for all incidents involving a patient including:

   1. All incidents of abuse, verbal attacks or aggressive behavior;

   2. All incidents resulting in injury;

d) Workers’ Compensation and insurance records if indicated;

e) Safety Committee Minutes and inspections are kept in accordance with requirements; and

f) Training program contents and sign-in sheets of all attendees are maintained.

g) Employee disciplinary notice where applicable.

Reference:

1UAMS Administrative Policy 4.4.02
2UAMS Administrative Policy 11.4.01
3Hospital Policy ML.1.04
5. Immigration Policies and Services

Employment of Immigrants and Aliens (Admin Policy 4.5.25)

Immigration Reform and Control Act of 1986 (Admin Policy 4.5.26)

Assistance and additional information on immigration issues is available through the Human Resources Department. Please visit their web site at http://www.uams.edu/ohr/Imm.asp.

10/13/2005
POLICY

The University of Arkansas for Medical Sciences (UAMS) may employ any immigrant or non-immigrant, provided that such employment conforms to the provisions of the Immigration and Nationality Act, as amended, the regulations of the Immigration and Naturalization Service (INS), and to those standards established by the University. Any decision reached by the University will not be affected by the race, color, age, religion, sex, handicap, national origin or veteran status of the prospective employee.

PROCEDURE

1. All applicants for employment with UAMS must present proof of valid work authorization to the Office of Human Resources for verification. No alien may be employed without proper authorization.
2. Departments expecting to hire non-US workers should contact the Office of Human Resources at least 70 days in advance of any scheduled interviews to ensure that paperwork may be processed through governmental agencies in a timely manner.

DEFINITIONS

1. The term "Alien" shall mean any person not a citizen or national of the United States.
2. The term "Immigrant" shall mean any alien who has been lawfully admitted to the United States for permanent residence. Immigrants are entitled to remain in the United States indefinitely, to own property, and to work and move about without restriction so long as such aliens comply with all laws relating to alien registration, changes of address and annual reports.
3. The term "Non-immigrant" shall mean any alien who has been granted temporary admission to the United States for specific purposes and is required to leave the country when the purpose of the temporary stay has been accomplished. Non-immigrants must maintain in their possession an arrival-departure record (INS Form I-94) with INS notations showing their period of authorized stay and an alphabetical symbol designating their classification within the non-immigrant group. The alphabetical symbol is followed by a number which indicates the specific category within the classification. For example, "B-1" is a visitor for business and "B-2" is a visitor for pleasure. The University recognizes the following classes of non-immigrants, whose right to gainful employment in the United States is restricted as indicated:

   a. Visitors for business, (B-1), and visitors for pleasure, (B-2) UAMS CODE: NONE

      Both B-1 and B-2 aliens are barred from employment, although B-1 aliens may engage in certain business activities consistent with their status, such as negotiating contracts, or selling or soliciting orders for goods manufactured abroad.

   b. Academic Students, (F-1), and their families, (F-2). UAMS Code: ST

      An F-1 student may accept on-campus employment at the school attended without obtaining prior approval from INS and without limitation on the number of working hours per week provided that: (1) the alien does not displace a U.S. resident; or (2) such employment is considered part of the student’s program under the terms of a scholarship, fellowship or assistantship. An F-1 student is authorized for off-campus employment only when INS has approved an individual application. Such approval allows the alien to work a maximum of 20 hours per week while school is in session, and full-time during vacation periods. The alien may work during the summer vacation however, only if registered for the following term or if eligible and intending to register for that term. Upon graduation or completion of their studies, F-1 aliens are eligible to accept employment in order to obtain practical training. This again requires prior approval by INS of an application. Aliens must make requests for practical training no later than 30 days after completion of their course curriculum. Permission to take practical training is
granted in increments of six months each, not to exceed a total of 12 months. F-2 spouses and children of F-1 aliens are barred from employment.

c. **Temporary workers and trainees (H-1, H-2, H-3), and their dependents (H-4). UAMS Code: TP**

   H-1 applies to aliens of distinguished merit and ability coming to the United States temporarily to perform services of an exceptional nature requiring such qualifications. H-2 applies to other aliens coming to the United States temporarily to work at temporary jobs in occupations where a shortage of American workers exists. H-3 applies to aliens coming to the United States temporarily for training not available in their home countries. H-1, H-2, and H-3 aliens may engage in only the specific employment previously authorized by INS and within the time shown on their Form I-797. Their H-4 dependents are barred from employment.

d. **Exchange visitors (J-1) and their dependents (J-2). UAMS Code: EX**

   The J-1 visa provides for the exchange of students, scholars, trainees, teachers, professors, researchers, specialists, and leaders in a specialized field of knowledge or skill for a specific program designated by the U.S. Information Agency. J-2 spouses and children may obtain permission from INS to accept employment only if such employment is necessary for their support - not for the support of the principal alien.

e. **Trade Canadian (TC) UAMS Code: NONE**

   Non-immigrant Canadians may come to the U.S. to work under the North American Free Trade Agreement, for renewable periods of a year.
The purpose of this policy is to make known the intentions of The University of Arkansas for Medical Sciences (UAMS) to comply with terms of the Immigration Reform and Control Act (IRCA) of 1986 in gaining proof of identity and eligibility for employment from every individual employed on or after November 6, 1986. Individuals who fail to show acceptable documentation of identity and eligibility to work will be allowed a grace period of 21 days after hire/appointment. Non-compliance thereafter will be cause for immediate termination.

PROCEDURE

1. Individual employees are responsible for producing acceptable documents, as specified by IRCA and listed on the Form I-9, in original format at the time of hire or appointment. The employee must sign the Form I-9. (See page 2 of this policy for a sample form).

2. The Office of Human Resources is responsible for adequately notifying each employee of this obligation, reviewing and photocopying documents, completing the Form I-9, and completing follow-up procedures with deficient employees by verbal and written communications.

3. Employees who cannot show documentation at the time of hire or appointment will be allowed 21 days from their hire date to complete the process. If documentation is not completed within 21 days, the employee will be terminated. This policy will be pursued in order to avoid potential IRCA civil and criminal penalties of non-compliance.

4. An employee terminated for non-compliance will be reinstated to pay status only with presentation of the acceptable documentation on the day of rehire.

5. Completed Form I-9 will be retained in the employee's personnel file for the greater of three years, or one year following termination.
Immigration Services

This page provides an overview of selected employment-based nonimmigrant and immigrant categories applicable to and for which UAMS provides services. For information in other areas of immigration, contact the local Immigration and Naturalization Service (INS) Office located at 245 Wagner Place, Suite 250, Memphis, Tennessee 38103; office hours M-F, 8 am-2 pm; Tel. 1-901-766-2968 (call between 9 am-12 pm. The 24-hour INS national recording, "Ask Immigration" is Tel. 1-800-755-0777. To order INS forms Tel. 1-800-870-3676. The INS Texas Service Center may be reached by Tel. 214-767-7769, FAX 214-767-7405.

Nonimmigrant Categories
Nonimmigrant categories applicable to UAMS that authorize employment are:

- F-1 Student
- J-1 Exchange visitor
- J-2 Exchange visitor dependent with work authorization
- TN-1 Canadian or Mexican professional
- H-1B Professional temporary worker

Student (F-1)
The F-1 classification is for a student who has been fully admitted at UAMS and issued a Certificate of Eligibility, Form I-20A-B. To prove eligibility for student status, the student must demonstrate that there is a foreign residence abroad which he has no intention of abandoning; that the student has a valid educational purpose for attending school in the U.S.; and that the student has sufficient funds with which to support self without working.

A student is admitted for duration of status (D/S), which is defined as the time during which he is pursuing a full course of study at an educational institution approved by the service for attendance by a foreign student, or engaging in authorized practical training following completion of studies, plus sixty days to prepare for departure from the United States.

A student is only authorized to attend the school which issued the I-20A-B. A student who wants to transfer to a new school must notify the present school of the transfer and obtain an I-20A-B from the new school.

The F-1 regulations provide for the following types of employment for an eligible student applicable to UAMS:

- On-campus employment
- Post-completion practical training
- Off-campus employment, based on economic necessity

On-campus employment must either be performed on the school's premises or at an off-campus location which is educationally affiliated with the school. Employment must not exceed twenty hours per week while school is in session. A student may work full time on campus when school is not in session or during the annual vacation.
A student may apply to INS for authorization for temporary employment for practical training after completion of studies. A student may request recommendation for practical training during a 120-day period which begins 90 days before and ends 30 days after the completion of the course of study. A student cannot accept employment until he has been issued an Employment Authorization Document by INS.

If other employment opportunities are not available or are otherwise insufficient, an eligible student may request off-campus employment work authorization based upon severe economic hardship caused by unforeseen circumstances beyond the student's control.

For further information, contact the Assistant to the Vice Chancellor for Academic Affairs, who is the Designated School Official (DSO), at the Graduate School Administration Office, Tel. 686-5454, Slot 601

**Exchange Visitor (J-1)**

UAMS has an approved exchange visitor program for researchers and students only, and can issue a Certificate of Eligibility for Exchange Visitor Status (form IAP-66) to post-graduate aliens and their immediate family. Graduate medical education must be sponsored through the Educational Commission for Foreign Medical Graduates, Tel. 215-662-1445.

An applicant for the J-1 must demonstrate that he has a foreign residence that he has no intention of abandoning; has sufficient funds for his stay; meets health insurance requirements for self and dependents, and has the English language proficiency required to participate in the program.

The J-1 exchange visitor is admitted for the time authorized by the category of the visit. Research scholars may stay in the U.S. in J-1 status for three years. Extensions are feasible for good cause.

Dependents (J-2) of an exchange visitor may apply for employment authorization with INS by filing form I-765.

If an exchange visitor is subject to the two-year foreign residence requirement, the alien must return to the country of nationality or last permanent residence for at least two years before being eligible to apply for H-1B or immigrant status. An exchange visitor is subject to the two-year foreign residence requirement if he or she:

- Received funding in whole or in part, directly or indirectly, from the country of the alien's last residence or from the U.S. government;
- Is a national or resident of a country designated by the Secretary of State as requiring the service of persons in the alien's particular field of knowledge or skill (Skills List); or
- Came to the U.S. to receive graduate medical education or training.

Although the J-1 exchange visitor is expected to honor a commitment to return to the home country, waivers of the two-year residency requirement may be applied for on the basis of persecution in the home country, exceptional hardship, a request from an interested U.S. government agency, and home-country non-objection. The last basis is unavailable for foreign medical graduates pursuing graduate medical education or training in the U.S.

For further information, contact the Immigration Manager, Office Human of Human Resources, Tel. 686-5074, Slot 566.

**North American Free Trade Agreement (TN-1)**

The North American Free Trade Agreement (NAFTA) provides TN classification for
Canadian and Mexican professionals to work in the U.S. The TN applicant must be engaged in one of the following professions listed (list annotated to be applicable to UAMS):

- Medical/allied professional (physicians-teaching and research only)
- Research assistant (working in a post-secondary educational institution)
  baccalaureate degree
- Scientist
- Teacher (University)

For further information contact the Immigration Manager, Office of Human Resources, Tel. 686-5074, Slot 566.

**Temporary Worker (H-1B)**
The H-1B classification is for an alien coming to the United States to perform services in a professional occupation. The law allows foreign medical graduates to come to the United States in H-1B status to practice medicine. Physicians involved in direct patient care specifically require:

- An Arkansas State license or authorization required by the State of intended employment, or State evidence that a license is not required (residents are exempt from this requirement); and
- A foreign medical license or foreign medical diploma or U.S. medical diploma; and
- USMLE, NBME, or equivalent, or medical diploma from a U.S. school; and
- ECFMG certificate with the English proficiency stamp or a graduate of a school of medicine accredited by the Secretary of Education.

To qualify for state licensure, the alien must have one year clinical experience in the United States.

The employer files an H-1B petition with INS after obtaining prevailing wage rate information and filing a labor condition application with the Department of Labor.

If the H-1B petition is approved and the alien is outside the U.S., the alien may apply for an H-1B visa at a consulate abroad. If the alien is in the U.S. and has maintained lawful status, the petitioner may apply for change of status on the alien's behalf. J-1 medical residents must depart the country to obtain the visa.

The petition may be filed for three years and extended for an additional three years. When an alien's H-1B status expires at the end of six years, the alien must remain outside the U.S. for one year before becoming eligible for another H-1B.

For further information, contact the Immigration Manager, Office of Human Resources, Tel. 686-5074, Slot 566.

**Immigrant-Permanent Resident**
For obtaining permanent resident ("green card") status through employment, the employer files an immigrant petition with INS to classify the alien for a visa under one of the employment based categories—Extraordinary Ability, Outstanding Researcher or Professor, Exceptional Ability in the National Interest and Advanced Degree in the National Interest. After the petition is approved, the alien files an application to adjust status through the local INS office in Memphis. A request for employment authorization is filed with the application and usually takes 90 days. Granting of the green card usually takes 10 months from date of application.

Another method is through a lottery. To qualify, an alien must come from a designated "low admission country" and be a high school graduate. Applying involves mailing a sheet of paper with: one's name, address, date and place of birth to INS.
For further information, contact the Immigration Manager, Office of Human Resources, Tel. 686-5650, Slot 566.

University of Arkansas for Medical Sciences
4301 W. Markham St., Little Rock, AR 72205

For the Office of Human Resources & Employee Services, Call 1-501-686-5650

To Make a Medical Appointment Call the Appointments Center at: 1-501-686-8000 or 1-800-942-8267
For Patient Information/Rooms, Call 1-501-686-6416
For General Information and for Numbers Not Listed, Call 1-501-686-7000
For International Patient Appointments, Call 1-501-686-8071

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6. **UAMS Policies Concerning Equal Employment Opportunities and Student Records**

- [Affirmative Action](#) (Admin Policy 4.5.01)
- [Americans with Disabilities Act](#) (Admin Policy 4.4.08)
- [Anti-Discrimination: Race, Color, Gender, Age, Sexual Orientation, Religion, National Origin or Disability](#) (Admin Policy 3.1.10)
- [Policy Prohibiting Sexual Harassment](#) (Admin Policy 3.1.05)

A complete listing of employment policies in the UAMS Administrative Guide may be found at [http://uams.edu/AdminGuide/index.html](http://uams.edu/AdminGuide/index.html).
The purpose of this policy is to inform all departments within the University of Arkansas for Medical Sciences (UAMS) of the commitment to do more than ensure employment neutrality with regard to race and gender. We will take affirmative action and/or make additional efforts to recruit, employ, and promote qualified African Americans, Hispanic, Asian Americans, Native Americans and females. The ability of UAMS to meet its mission will increasingly depend on and be strengthened by incorporating constructive diversity in its faculty, students and staff.

**POLICY**

UAMS will comply with and enforce the applicable laws--Title VII of the Civil Rights Act of 1964 (as amended), Executive Order 11246, U.S. Federal Court Decree in the Adams Cases of 1973, and Act 99 of the Arkansas General Assembly. UAMS will take positive actions to overcome institutional forms of exclusion and discrimination. It is not sufficient to just take benign neutrality with regard to race and gender in employment practices.

**PROCEDURE**

1. UAMS will do more than ensure neutrality with regard to race and gender but will actively recruit, employ, admit and retain African Americans, Hispanic, Asian Americans, Native Americans and females.
2. UAMS will implement positive and innovative efforts to enhance the quantity and the quality of the minority applicant pool.
3. All hiring units that advertise or list job vacancies in newspapers, professional journals, magazines and other media will also advertise in minority publications, if appropriate. All jobs must be posted for a minimum of 5 days. (See 4.5.09, Personnel Requisition)
4. UAMS will use race and gender in some special situations where these individuals have been historically and institutionally excluded, e.g., when the final applicant's applications are equal and there are not any minorities or females in the department and/or section where the vacancy occurs, the person or persons making the final decisions as to whom to hire will be mindful of incorporating constructive diversity in the workforce.
5. UAMS will continue to recruit, employ and admit minorities to areas where they either do not exist or are present in numbers less than represented in the relevant labor market.
6. At the end of each academic year, each college and administrative unit will submit to the Human Relations Office an Affirmative Action/Desegregation Progress Report.
7. UAMS will take remedial steps and affirmative action to eliminate and overcome all vestiges of discrimination, which have or may have resulted from previous policies and practices.
8. Complete the "Affirmative Action Review Form" and forward to the Director of Human Relations, slot 544. This form is sent to the hiring department during the recruitment process; or copies can be obtained by calling the Office of Human Resources at 686-5650.

**REFERENCES**

UAMS Policy 4.5.09 Personnel Requisition
UAMS Policy 4.5.11 Job Advertisements
PURPOSE

The University of Arkansas for Medical Sciences desires a uniform and thorough application of the Americans with Disabilities Act (ADA) with regards to applicants and employees. This policy will serve as a guide to managers and supervisors in their responsibility under this Act.\(^1\)

POLICY

1. The University of Arkansas for Medical Sciences does not discriminate on the basis of disability in any term, condition, or privilege of employment. All aspects of employment are covered, including social and recreational programs.
2. Non-discriminatory assurances are given to all individuals.
3. An individual with a disability is a person who:
   - has a physical or mental impairment which substantially limits one of life’s major activities of caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, working, sitting, standing, lifting, and reaching; included within this definition are any physiological disorder or condition, cosmetic disfigurement or anatomical loss, and any mental or psychological disorder
   - has a record of such an impairment.
   - is regarded as having such an impairment.
   - is associated with an individual with a disability.
4. UAMS will not limit, segregate, or classify applicants or employees which thereby affects their opportunities or status because of their impairment.
5. The Office of Human Resources will assure that all tests and other selection criteria accurately reflect skills and aptitudes necessary to perform the job, are business related, and are consistent with business necessity. Further, standards, criteria, and methods of administration will not have the effect of discrimination on the basis of disability.
6. OHR will assure that inquiries into the nature and/or severity of an individual’s disability will be job related and will occur only after a conditional offer of employment.
7. OHR will assure that all medical records for employees are maintained separately and confidentially as required by the ADA. Likewise, worker compensation and benefit histories are maintained separately from master personnel files.
8. UAMS will avoid contractual or other arrangements that may subject an applicant or employee with an impairment to discrimination.

PROCEDURE

1. Managers and supervisors will identify the essential functions of the job and the essential physical requirements for each position reporting to them, and will make decisions of hiring, promotion, demotion, performance evaluation, and other employment actions on the basis of these essential criteria. Such essential functions shall be identified in Position Classification Questionnaires (PCQ) and in Personnel Requisitions, and shall be reflected in performance evaluation documents.
2. When a qualified individual with an impairment, either an applicant or a current employee, is unable to perform the essential functions of the position unassisted, the manager or supervisor will seek "reasonable accommodation" so that the individual is enabled to perform the essential functions. The process of finding available options for "reasonable accommodation" should include the input of the individual with the impairment, OHR and outside support agencies when necessary.
3. The manager or supervisor will contact OHR for guidance prior to taking any employment action when:
   - a "reasonable accommodation" for the qualified individual with a impairment cannot be found,
   - such accommodation poses an "undue hardship" on the department,
   - the qualified individual with an impairment might pose a health or safety hazard to employees, visitors, or patients, OR
   - the individual cannot be hired or be continued in employment because of inability to perform the essential functions of
4. In a case where the accommodation seems to be an "undue hardship," OHR will assist the department in seeking alternative accommodations and in finding additional financial and other resources from the University and/or the State of Arkansas in order to accomplish the necessary accommodation.

5. Managers and supervisors should participate in basic management training on the ADA as offered by the OHR and the UAMS Training Consortium.

REFERENCE

1 UAMS Policy 3.1.12 Compliance with the Americans with Disabilities Act

The University of Arkansas for Medical Sciences desires a uniform and thorough application of the Americans with Disabilities Act (ADA) with regards to applicants and employees. This policy will serve as a guide to managers and supervisors in their responsibility under this Act.
PURPOSE

The University of Arkansas for Medical Sciences (UAMS) is committed to the principle and practice of nondiscrimination and equal opportunity in all areas of employment and other services that affect employees, students and the general public. The ability of UAMS to meet its mission will increasingly depend on and be strengthened by incorporating constructive diversity in its faculty, students and staff. Racism, bigotry and discrimination subvert the mission of UAMS which is to provide a wholesome environment where comprehensive educational, research and employment opportunities are offered to employees and students. In both obvious and subtle ways racism, bigotry and discrimination adversely affect an individual's ability to function at optimal level. They also have a harmful effect on one's ability to study, work and engage in leisure activities within the University community.

POLICY

The University of Arkansas for Medical Sciences abhors and condemns all forms of bigotry and racism. Such behavior is a violation of an individual's human rights and is also unlawful. UAMS will comply with and enforce Titles VI and VII of the Civil Rights Act of 1964 (as amended), Executive Order 11246, Title IX of the Educational Amendments of 1972, the Rehabilitation Act of 1973 (Sections 503 and 504), the Age Discrimination in Employment Act, the Americans With Disabilities Act of 1991, U.S. Federal Court Decree in the Adams Cases of 1973 and Acts 99 and 962 of the Arkansas General Assembly. UAMS shall recruit, retain, promote and graduate students without regard to race, color, gender, age, sexual orientation, religion, national origin or disability status. Specifically, UAMS will not discriminate on the basis of race, color, gender, age, sexual orientation, religion, national origin or disability status as a criterion in deciding against any individual in matters of admission, placement, transfer, hiring, dismissal, compensation, fringe benefits, training, tuition assistance and other personnel or educationally-related actions.

Therefore, the policy of UAMS is that members of the University community neither commit nor condone acts of bigotry, racism or discrimination. Actions on the part of any employee or official of the University contrary to this policy will be addressed promptly and appropriately, according to current UAMS disciplinary procedures. To ensure compliance with this adopted policy of nondiscriminatory behavior, UAMS will operate under the following procedures.

PROCEDURE (TRAINING & EDUCATION)

1. UAMS shall institute an on-going program designed to familiarize UAMS personnel with the fundamental principles of racial tolerance and cultural diversity. Priority will be given in the training of:

   a. Faculty
   b. Supervisory and management personnel
   c. Personnel involved with customer contact
   d. Students
   e. Other personnel

2. Deans and division heads will be responsible for leading in the development and implementation of educational programs in their respective areas. The Office of Human Resources will be available, as a primary resource, for consultation in all areas of program development. The Office of Human Resources will also be a leader in the development and presentation of educational programs.

3. All promotional programs designed to solicit funds, provide customer information or create community goodwill, shall reflect the diversity of the University community and the general public. The appropriate dean/division head, or designee shall review such material prior to publication to ensure that the above standard is met.

4. Production of all faculty handbooks, student handbooks, employee handbooks, as well as any other communication designed to
publicize policy and procedure, or any other information, must be written in a manner to promote nondiscriminatory and tolerant behavior. The appropriate administrative personnel shall review such material prior to publication to ensure the above standard is met.

PROCEDURE (RACIAL SLURS, JOKES AND DEROGATORY REMARKS)

5. All complaints or allegations of slurs, inscriptions, jokes or other offensive behavior based on race, color, gender, age, sexual orientation, religion, national origin, or disability which occur in the workplace or are related to the workplace are to be reported to the appropriate department head. Any employee, faculty member, or student may contact the Human Relations Office should the complainant feel uncomfortable in reporting the incident to the department head.

6. (Campus Policy 4.4.02) Progressive discipline will be implemented in proven cases of behavior referenced in Procedure #5 above:
   a. First Offense -- Verbal Reprimand
   b. Second Offense -- Written Disciplinary Notice
   c. Third Offense -- Termination of Employment

Sensitivity training will be made available for those employees guilty of the behavior described in Procedure #5.

PROCEDURE (MONITORING)

7. During the month of June of each year, the Diversity Committee will review and report to the Chancellor the University's progress in the above areas of operation. This will be accomplished by review of such documents as the University's Affirmative Action plan, reports of accomplishments submitted by division heads, reports submitted to the Chancellor, and any other documented activities designed to accomplish the goals set out in this policy.
PURPOSE

The University of Arkansas for Medical Sciences (UAMS) is committed to its mission of providing an academic and employment environment that fosters excellence. Sexual harassment violates the trust and respect essential to the preservation of such an environment, and threatens the education, careers, and well being of its community members. University members have the right to work and study in an environment free of harassment. This right is protected by Title VII of the 1964 Civil Rights Act for employees and Title IX of the Educational Amendments of 1972 for students, which view sexual harassment as a form of sexual discrimination. For these reasons, harassment of any kind will not be tolerated at UAMS. In both obvious and subtle ways, the very possibility of sexual harassment is destructive to individual students, faculty, staff, and the UAMS community as a whole.

Sexual harassment is particularly serious when it threatens relationships between teacher and student, or supervisor and subordinate, because it unfairly exploits the power inherent in these relationships. When, through fear of reprisal, a student or employee submits or is pressured to submit, to unwanted sexual attention, the ability of UAMS to carry out its mission is undermined. UAMS strongly encourages all UAMS community members to report incidents of sexual harassment. To that end, reporting and investigating procedures are supportive of and sensitive to the alleged victim. At the same time, they adequately safeguard the rights of the alleged offender.

POLICY

The University of Arkansas for Medical Sciences opposes all forms of sexual harassment, whether subtle or direct, and is committed to the thorough, timely and confidential investigation, in a fair and impartial manner, of all complaints from its students or employees. UAMS shall establish an independent Resource Panel for the purpose of providing counseling assistance for individuals who believe they have been victims of sexual harassment. Additionally, members of the panel may be called upon to investigate complaints of sexual harassment and provide the Assistant Vice Chancellor for Human Services with a written report of their findings. The Chancellor shall appoint a Resource Panel made up of twelve individuals nominated by the Heads of each UAMS Division. The Panel's membership shall reflect the diversity of the campus, and shall be divided into three groups of four members, with each group serving one, two, and three year terms, respectively. After the initial period, members shall be appointed to serve three year terms. The Panel members shall be trained in issues relating to sexual harassment, as well as in the proper manner of investigating complaints, and shall be certified as to completion of such training by the Assistant Vice Chancellor for Human Services. The Assistant Vice Chancellor for Human Services shall select individuals from the panel to conduct an investigation when a complaint of sexual harassment is received.

All individuals who believe that they have been sexually harassed are encouraged to notify their immediate supervisor, department head, or one of the resource persons from the independent Resource Panel appointed by the Chancellor. Names and contact numbers of panel members shall be published in the UAMS Administrative Guide as part of this policy. All individuals accused of sexual harassment shall be given the opportunity to respond to the complaints prior to any employment decisions. All records of sexual harassment complaints, whether filed by employees or students, shall be maintained in confidential files by the Office of Human Resources. Employees and students who are found guilty of sexual harassment are subject to disciplinary action in accordance with UAMS policies.

DEFINITIONS

Sexual harassment of employees and students is defined as any unwelcome sexual advance, request for sexual favors, or other physical or verbal behavior of a sexual nature either in or out of the work place when:

1. Submission to or rejection of the conduct is made either explicitly or implicitly a term or condition of employment or status in a course, program, or activity;
Submission to or rejection of the conduct is used as a basis for an employment or educational decision affecting an individual; or

Such behavior unreasonably interferes with an individual's work or educational performance, or creates an intimidating, hostile, or offensive environment for work or learning.

Incidents that fall within the above defined criteria may occur between individuals of different sex -- male against female, or female against male -- or, between individuals of the same sex. Additionally, incidents may occur between supervisor and employee, faculty member and student, or between fellow-employees and fellow-students; they may also take place between employees and campus visitors and between employees and those who do business with UAMS.

**EXAMPLES**

The perception of what constitutes sexual harassment may vary from individual to individual; what is offensive to one person may be less so to another. Nevertheless, in both instances, complaints may arise alleging sexual harassment. The following examples are intended as illustrations only; they do not cover all possible situations. Some may be isolated and inadvertent offenses while others may be blatant and serious.

(1) **Isolated and Inadvertent Offenses**

a) One-time or occasional comments of a sexual nature, or sexually explicit statements -- often unintentional, the perpetrator failing to realize that his/her actions discomfort or humiliate an individual or individuals (e.g., off-color statements, questions, jokes, or anecdotes);

b) Spontaneous suggestive whistling, catcalls, or other gestures that call attention to one's sexuality;

c) Body language, such as repeated staring, may be interpreted as pressure for sexual attention.

(2) **Blatant and Serious Offenses**

a) Physical assault;

b) Repeated and/or intentional behavior that constitutes a pattern where actions seriously discomfort or humiliate an individual (e.g., off-color statements, questions, jokes, or anecdotes) when the perpetrator has been warned previously;

c) Persistent, unwelcome flirtations, and outright advances and/or propositions of a sexual nature;

d) Unwelcome remarks or actions of a sexual nature about an individual's body or clothing;

e) Unnecessary touching, such as patting, pinching, hugging, or repeated brushing against an individual's body;

f) Suggestions that submission to or rejection of sexual advances will influence decisions regarding such matters as an individual's employment, salary, academic standing, work assignments or status, grades, award of financial aid, or letters of recommendation;

g) Unwarranted displays of sexually suggestive objects or pictures;

h) Unwelcome exposure to sexually explicit music, letters, or written notes;

i) Descriptions of sexual activity or speculations about previous sexual experiences;

**SPECIAL CIRCUMSTANCES**

There are special circumstances when a staff member of an academic medical center may be at risk of being sexually harassed by individuals who are not employed by the institution. This might include employees of those who do business with UAMS. Investigative steps should be taken as outlined in this policy and appropriate warnings should be made if the action is found to have occurred. If such is the case, and the inappropriate behavior does not cease, UAMS shall take suitable action.

**CONSENSUAL RELATIONSHIPS**

Consenting amorous relationships between faculty members and students or between supervisors and employees are of particular concern to UAMS and are strongly discouraged. The relationship between faculty member and student or supervisor and employee should be one of trust and mutual respect, thus fostering an atmosphere of professionalism. Faculty members exercise power over students as do supervisors over employees, whether in evaluations, recommendations, study, duties, grades, assignments, or other benefits. This differential in power increases the opportunity for abuse of power, thus endangering the professional environment. In addition, faculty or supervisors who have chosen to enter consensual relationships with subordinates, should be aware of the possible difficulty in defending a future sexual harassment charge on the grounds of mutual consent.

**PROCEDURE (INFORMAL COMPLAINTS)**

UAMS recognizes that it is advantageous, where possible, to resolve complaints informally. The informal process is intended as a means of addressing misunderstandings between individuals which have resulted in a complaint of sexual harassment. Employees with complaints are
encouraged to notify their immediate supervisor, department head, or one of the resource persons from the independent Resource Panel. Students should report incidents of sexual harassment to the appropriate College's Student Affairs Office. Some complaints may be addressed informally by speaking directly with the accused to make them aware that the conduct is perceived as unwelcome. The informal process may also include referral of either or both parties in the complaint to confidential counseling through UAMS' Employee Assistance Program (EAP). The complainant or administrator may elect to refer the complaint into the formal campus procedure at any time during the process, as they deem necessary to resolve the complaint in an appropriate and timely manner.

**PROCEDURE (FORMAL COMPLAINTS)**

Where the informal process fails to resolve the complaint, or in instances where the alleged harassment is blatant, the University's formal complaint process will be used. The Director of Employee Relations in the Office of Human Resources or the University's Director of Human Relations may assist the complainant in preparing their complaint in writing, as necessary. The complaint will be directed to the Assistant Vice Chancellor for Human Services. Upon receipt of the written complaint, the Assistant Vice Chancellor for Human Services will notify the appropriate Dean, Vice Chancellor, or Executive Director, and appoint two members of the Resource Panel to investigate the facts of the complaint.

The assigned resource persons will interview the complainant to review facts presented in their complaint, and to determine any additional information pertinent to evaluating the complaint. The resource persons will also interview the accused, and present them with a written copy of the complaint. Each party will be asked to identify other individuals who may have direct pertinent knowledge relating to the complaint. The accused will also be given the opportunity to respond in writing to the complaint prior to completion of the investigation. The resource persons will attempt to interview all individuals identified by either party. Every effort will be made to ensure a thorough and timely investigation of the complaint.

Following completion of the investigation of the complaint, the resource persons will meet with the Assistant Vice Chancellor for Human Services and the appropriate division Dean, Vice Chancellor, or Executive Director to present the facts. A written report, outlining data collected in the interview process, will be presented at that time. The Dean, Vice Chancellor, or Executive Director will be responsible for the timely disposition of the complaint. The Assistant Vice Chancellor for Human Services will be available to consult with the division head regarding policy issues relating to the disposition of the complaint.

Employees may appeal any employment decision through the campus grievance procedure. Students who are found guilty of sexual harassment may appeal the decision, and any subsequent action taken, through the grievance procedure of their respective college. Individuals found to have intentionally filed false complaints of sexual harassment will be subject to disciplinary action in accordance with UAMS' policies on employee/student conduct. Complainants may not appeal administrative decisions regarding sexual harassment complaints through the UAMS grievance processes.

Any specific questions regarding the process for making a complaint may be directed to the Office of Human Resources ext. 6-5300, or the Office of Human Relations ext. 6-5945.

**EDUCATION**

The aim of education on sexual harassment is not just to end specific harassment but to help create a positive climate for working and learning within the UAMS community. The presentation of information develops awareness and acceptance of major differences among the members of this community. Therefore, this policy on sexual harassment shall be disseminated to all individuals associated in any way with the University of Arkansas for Medical Sciences. This shall include all full and part-time employees and students, as well as all businesses and their representatives who are involved with UAMS.

An educational program will be developed through the Office of Human Resources and presented to all current members of the UAMS community. This program shall be mandatory for all, and documentation of attendance will be placed in each member's file. This same program will be incorporated into the existing orientation programs for new employees and students. Each UAMS division director (Vice Chancellors, Deans, and Executive Directors) will be responsible for disseminating this educational program to their respective organizations.
Faculty Resources

7. UAMS HIPAA Policies and Services

- Accounting for Disclosure (Admin Guide 3.1.26)
- Business Associate Policy (Admin Guide 3.1.33)
- Confidentiality Policy (Admin Guide 3.1.15)
- Creating Revision of UAMS Policies Involving HIPAA Administrative, Security or Privacy Requirements (Admin Guide 3.1.39)
- De Identification of Protected Health Information and Limited Data Set Information (Admin Guide 3.1.31)
- HIPAA Education and Training (Admin Guide 3.1.30)
- HIPAA Research Policy (Admin Guide 3.1.27)
- Information Access or Transfers and Terminations (Admin Guide 3.1.41)
- Minimum Necessary Policy (Admin Guide 3.1.25)
- Mitigation of Uses/Disclosures in Violation of HIPAA (Admin Guide 3.1.22)
- Mobile Device Safeguards (Admin Guide 3.1.17)
- Notice of Privacy Practices (Admin Guide 3.1.21)
- Patient Information Restriction Requests (Admin Guide 3.1.34)
- Patient Request to Amend Medical Records or PHI (Admin Guide 3.1.32)
- Policy on Use of PHI for Fundraising (Admin Guide 3.1.35)
- Psychotherapy Notes Policy (Admin Guide 3.1.24)
- Request for Alternative Method of Communications of Protected Health Information (Admin Guide 3.1.18)
- Releasing of Patient Directory Information (Admin Guide 3.1.20)
- Reporting of HIPAA Violations (Admin Guide 3.1.23)
- Request for Extracts (Admin Guide 3.1.29)
- Safeguarding Protected Health Information (Admin Guide 3.1.38)
- Use and Disclosure of PHI and Medical Records (Admin Guide 3.1.28)
- Use of PHI for Marketing (Admin Guide 3.1.36)
Verification of Identity (Admin Guide 3.1.37)

Working from Home (Admin Guide 3.1.40)

Assistance and more information is available through the UAMS HIPAA Office (http://hipaa.uams.edu/).

Back

10/13/2005
Accounting for Disclosures is a method of documenting and tracking certain types of disclosures of Protected Health Information (PHI) made by UAMS, verbally or in writing, to persons or entities who are not a part of UAMS.

Disclosure means the release, transfer, provision of access to, or divulging of information in any manner (verbally or in writing) by UAMS to persons who are not UAMS employees or students, or to any other person or entity outside of UAMS.

Protected Health Information (PHI) means information that is part of an individual’s health information that identifies the individual or there is a reasonable basis to believe the information could be used to identify the individual, including demographic information, and that (i) relates to the past, present or future physical or mental health or condition of the individual; (ii) relates to the provision of health care services to the individual; or (iii) relates to the past, present, or future payment for the provision of health care services to an individual. This includes PHI which is recorded or transmitted in any form or medium (verbally, or in writing, or electronically). PHI excludes health information maintained in educational records covered by the federal Family Educational Rights Privacy Act and health information about UAMS employees maintained by UAMS in its role as an employer.

UAMS Workforce means physicians, employees, volunteers, residents, students, trainees, visiting faculty, and other persons whose conduct, in the performance of work for UAMS, is under the direct control of UAMS, whether or not they are paid by UAMS.

POLICY

UAMS will establish and maintain a system for Accounting of Disclosures as required by HIPAA.

Beginning April 14, 2003, a UAMS patient may request an Accounting of Disclosures of his or her own PHI for up to a period of six years prior to the patient’s date of request. UAMS is not required to account for any disclosures made prior to April 14, 2003

A. Disclosures Exempt From Accounting: The following types of disclosures do NOT have to be included in the Accounting of Disclosures. Disclosures that were made:

1. for treatment of the patient, for payment of or reimbursement for healthcare services provided to the
patient, or for health care operations see UAMS Use and Disclosure of PHI and Medical Records Policy, 3.1.28 for more information on the use and disclosure of PHI for treatment, payment and health care operations which do not require patient authorizations or accounting for disclosures;

2. directly to the patient about their own information;

3. disclosures permitted by a signed patient authorization;

4. from a patient directory;

5. to individuals involved in the patient’s care;

6. for national security or other intelligence purposes;

7. incident to a permitted use or disclosure;

8. for purposes of a Limited Data Set in which the patient’s information that could identify the patient is excluded from the Data Set;

9. to correctional institutions or law enforcement when the patient is an inmate or otherwise in their lawful custody;

10. disclosures to and by Business Associates with whom UAMS has a Business Associate agreement, as long as the disclosures are for an exempt purpose, such as for payment or health care operations of UAMS; or

11. any disclosures made prior to April 14, 2003.

B. Disclosures Subject to Accounting Requirement: Except for any disclosures described above in Paragraph I, disclosures required or allowed by law without patient authorization must be included in the accounting. (Also refer to applicable section of the UAMS Use and Disclosure of PHI and Medical Records Policy, #3.1.28).

Examples of disclosures which MUST BE INCLUDED in an accounting include, but are not limited to, the following disclosures (if there is no signed authorization by the patient that meets the HIPAA authorization requirements set forth in the UAMS Use and Disclosure of PHI and Medical Records Policy, #3.1.28).

1. Arkansas Department of Health for TB, HIV, STD, or other infectious disease reporting.

2. Arkansas Department of Health for State Health Data Clearinghouse reporting;

3. Arkansas Department of Health, Division of Vital Records, for reporting of births or deaths;

4. FDA reporting for death, adverse event, or devices subject to tracking;

5. Organ, eye and tissue donation agencies;

6. Registries outside of UAMS which require disclosures, such as Cancer Registry, Immunization Registry, and Trauma Registry;

7. Spinal Cord injury reporting;

8. Cases of abuse/neglect requiring reporting to authorities;

9. County Coroner or County Sheriff for sudden infant death cases;
10. County Sheriff and City Policy to report intentional infliction of knife or gunshot wounds;

11. U.S. Department of Health and Human Services for purposes of investigating or determining UAMS’ compliance with HIPAA regulations;

12. Coroners and Medical Examiners to identify a deceased person or to determine cause of death or to perform other duties authorized by law;

13. State Crime Lab, if (1) specimen is accompanied by a label with PHI on it; and (2) release is performed without authorization;

14. Funeral Directors;

15. Courts or administrative agencies in response to subpoena, warrant, or similar process authorized by law;

16. Other law enforcement purposes, such as providing PHI to law enforcement about a suspected or actual crime victim, and to avert a serious threat to the health or safety of a person or to the public (unless law enforcement has requested that accounting not be provided for a specified period of time);

17. Disclosures to and by Business Associates with whom UAMS has a Business Associate agreement, only if the disclosures are not for an exempt purpose, such as for payment or health care operations of UAMS.

C. Research: UAMS must provide an accounting of disclosures of PHI in connection with research projects when there is no patient authorization for the disclosures, unless the disclosures are limited to PHI furnished in Limited Data Sets to recipients under a Data Use Agreement or a De-identified Record Set as defined in the UAMS De-Identification of PHI Policy, #3.1.31. UAMS must provide an accounting of disclosures of PHI pursuant to the waiver process. Refer to UAMS HIPAA Research Policy, #3.1.27 for more information regarding the accounting of disclosure requirements for Research.

D. For Victims of Neglect, Domestic, or Child Abuse: UAMS must provide an accounting of disclosures made for these purposes unless specifically exempted. In cases of domestic or child abuse, if UAMS has reason to believe that release to the patient’s personal representative could endanger the patient, UAMS has the discretion to decline the request.

E. Temporary Suspension of Request for Accounting: UAMS may temporarily suspend granting a patient’s request for an accounting if a health oversight agency or law enforcement official has provided UAMS with a written statement that the accounting to the patient may likely impede their activities. The written statement must also specify the time for the suspension. If the statement from the agency or official is made orally, then the suspension is limited to no longer than 30 days. UAMS must document the statement and the identity of the agency or official making the statement.

F. Time Period for Complying with Request for Accounting: UAMS must provide the patient with the accounting within sixty (60) days of the request. If unable to do so, UAMS must provide the patient with a written explanation for the delay and the date by which the accounting will be provided, not to exceed 90 days from the date of the request. This extension is permitted only once on a request for accounting.

G. Fees/Charges: The first accounting requested by the patient in any 12-month period is free. For each subsequent request by the patient in the same 12-month period, UAMS may charge a reasonable, cost-based fee, including reasonable retrieval and report preparation costs, as well as any mailing costs, only if the patient knows of such fees in advance and has the opportunity to withdraw or modify the request to avoid or reduce the fee.

PROCEDURE
A. **Recording Data for Accounting:**

1. UAMS will maintain the information necessary to provide an Accounting. Employees provided access to the “UAMS Release and Disclosure System” software or those employees utilizing a manual or other electronic disclosure Accounting system must record all required information for each disclosure that is subject to accounting.

2. All data must be recorded on the “UAMS Release and Disclosure System” by direct electronic entry or manual or other electronic entry on a copy of the Disclosure Reporting form (attached) or by manual entry on an Accounting Log Form (attached) or other Accounting form kept in the patient’s medical record or other official file. The information recorded must include:
   
   a. The date of disclosure;
   
   b. The name/address of entity or person receiving the PHI;
   
   c. A brief description of the PHI disclosed; and
   
   d. Either a brief statement of the purpose of the disclosure that reasonably informs the patient of the basis of the disclosure; a copy of the patient’s written authorization for the disclosure, or a copy of the written request for the disclosure, if any.

3. For multiple disclosures the accounting may provide the information in Item 2 above for the first disclosure, the frequency or number of disclosures made during such period and date of the last disclosure during the period.

B. **Obtaining and Accounting of Disclosure:**

1. Patients or authorized individuals will be directed to the Medical Records Department to request the Accounting. Requests for Accountings must be made in writing by using the attached Accounting of Disclosures form.

2. The Medical Records Department will process the request and give or mail the Accounting to the patient or authorized individual. Records personnel must record the date of the request and the date and name of the individual receiving the accounting.

   **Please use Word file forms (click on document icon at the top of page)**
Request for an Accounting of Disclosures

Date of Request: ___________________________

Patient Name: ___________________________________________________________________

Date of Birth : ___________________________

Medical Record Number: __________________________________

Patient Address :

________________________________________________________________________________

Address to send accounting of disclosure (if different than above):

________________________________________________________________________________

________________________________________________________________________________

Dates Requested:

I would like an accounting of disclosures for the following time frame:

(Please note: The earliest "from date" is April 14, 2003.)

From: ____/____/____       To: ____/____/____

(no earlier than April 14, 2003)

Fees:

The first request in a 12-month period is free.

There may be a charge for subsequent requests in that same 12-month period
The fee for this request will be: ______________________________

I understand that there may be a fee for this accounting, and I wish to proceed with my request. I also understand that the accounting will be provided to me within 60 days unless I am notified in writing that an extension of up to 30 days is needed.

__________________________________Signature of Patient or Legal Representative
Date

If Legal Representative, authority of Legal Representative ______________________________________
(such as parent of a minor, court-appointed guardian, administrator of estate of deceased, attorney-in-fact appointed with power of attorney, or healthcare proxy)

<table>
<thead>
<tr>
<th>For Healthcare Organization Use Only:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Received: ________________ Date Accounting Sent: ________________</td>
</tr>
<tr>
<td>Extension Requested: No [ ] Yes [ ] Reason: ______________________________</td>
</tr>
<tr>
<td>Patient notified in writing on this date: ______________________________</td>
</tr>
<tr>
<td>Staff Member Processing Request: ______________________________________</td>
</tr>
</tbody>
</table>

BAR CODE  Med Rec 2323 (G-3/03 – HIPAA) 6 of 7
Disclosure Reporting Form

Instructions: This form is used to document patient disclosures that are subject to a patient’s request for an “Accounting of Disclosures.” Refer to Accounting of Disclosures Policy. Fill out the information below and send the form to Slot 524.

Name of the person making the disclosure: __________________________________________________

Location: ____________________________________

Phone #: ______________________________

*   *   *   *   *   *   *

Patient Name: _______________________________________________________________________

Last Name / First Name / MI

Date of birth: _________________________________

Medical Record #: _______________________

Brief description of the information disclosed.

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

Date of the disclosure: _________________________ (MM/DD/YYYY)

Brief statement of the purpose of the disclosure.

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

Name of person or entity who received the information and address (if known).
Name of person filling out this form, if different than above:
UAMS ADMINISTRATIVE GUIDE

NUMBER: 3.1.33
DATE: 04/01/03
REVISION: 03/01/04

SECTION: ADMINISTRATION
AREA: GENERAL ADMINISTRATION
SUBJECT: BUSINESS ASSOCIATE POLICY

COPE

UAMS Workforce

DEFINITIONS

**Business Associate** is a person or entity who is not a member of the UAMS Workforce, and who performs or assists in the performance of, a function of activity for or on behalf of UAMS which involves disclosures that are regulated and permitted by HIPAA and which involve the creation, use or disclosure of Protected Health Information by the Business Associate.

**Designated Record Set** means a group of records maintained by or for UAMS in which the records are (i) medical records and billing records about patients maintained by or for UAMS; or (ii) enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or (iii) records used, in whole or in part, by or for UAMS to make decisions about patients. For purposes of the term “records” in this definition of Designated Record Set, this includes any item, collection or grouping of information that includes Protected Health Information and is maintained, collected, used or disseminated by or for UAMS.

**Disclosure** means the release, transfer, providing access to, or divulging of Protected Health Information in any other manner (verbally or in writing) outside of UAMS.

**Healthcare Operations** is defined by the HIPAA regulations under 45 C.F.R. § 164.501 and is incorporated herein by reference, and includes, but is not limited to, the following:

a. Quality assessment and improvement, including outcomes evaluation and development of clinical guidelines; population-based activities relating to improving health, protocol development, case management and case coordination, contacting providers and patients with information about treatment alternatives; and related functions that do not include treatment.

b. Accreditation, certification, licensing or credentialing activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs in which students, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as health care providers, training of non-health care professionals.

c. Conducting or arranging for medical review, legal services and auditing.

d. Business planning and development related to managing and operating the entity.

e. Business management and general administrative activities, such as fundraising and marketing of services to the extent permitted without authorization, disclosure of PHI in a due diligence review or to resolve internal grievances, and customer service.

**Organized Health Care Arrangement (“OHCA”)** means (i) a clinically integrated care setting in which individuals typically receive health care from more than one health care provider; or (ii) an organized system of
health care in which more than one covered entity participates, and in which the participating covered entities hold themselves out to the public as participating in a joint arrangement and participate in joint activities of at least one of the following: utilization review, quality assessment/improvement activities, or payment activities if the financial risk for delivering health care is shared, in whole or in part, by the participating covered entities. See HIPAA regulations for a more complete definition.

**Payment** includes billing, reimbursement, and collection activities relating to the provision of healthcare to an individual, including but not limited to, release to an insurance company, insurance plan or other third-party payer in connection with payment activities, eligibility or coverage determinations, disclosures to consumer reporting agencies, healthcare data processing, claims management and other activities as defined by 45 C.F.R. § 164.501 under “payment.”

**Protected Health Information (PHI)** means information that is part of an individual’s health information that identifies the individual or there is a reasonable basis to believe the information could be used to identify the individual, including demographic information, and that (i) relates to the past, present or future physical or mental health or condition of the individual; (ii) relates to the provision of health care services to the individual; or (iii) relates to the past, present, or future payment for the provision of health care services to an individual. This includes PHI which is recorded or transmitted in any form or medium (verbally, or in writing, or electronically). PHI excludes health information maintained in educational records covered by the federal Family Educational Rights Privacy Act and health information about UAMS employees maintained by UAMS in its role as an employer.

**Required by Law**: “Required by Law” generally means a requirement in the law that compels a person or entity to act or prohibits a person or entity from acting and that is enforceable in a court of law, including the requirements of any applicable federal or state laws and regulations.

**UAMS Workforce**: UAMS Workforce includes UAMS physicians, employees, volunteers, residents, students, trainees, visiting faculty, and other persons whose conduct, in the performance of work for UAMS, is under the direct control of UAMS, whether or not they are paid by UAMS.

### POLICY

Prior to disclosing any Protected Health Information to a Business Associate of UAMS, UAMS will obtain satisfactory assurances from a Business Associate that the Business Associate will appropriately safeguard the Protected Health information it receives or creates on behalf of UAMS. UAMS will document these satisfactory assurances in writing in the form of a Business Associate Agreement or other written agreement with the Business Associate in compliance with the HIPAA regulations. Any disclosures to a Business Associate must be limited to disclosures permitted by the HIPAA regulations and not for the Business Associate’s independent use or purposes.

### PROCEDURES

1. **DETERMINE IF PERSON or ENTITY IS A BUSINESS ASSOCIATE.**

   Based on the definition of “Business Associate” as stated in this Policy, a Business Associate is not a member of the UAMS Workforce. A Business Associate generally is a person or entity that performs certain functions or activities on behalf of UAMS, or provides services to UAMS, that are regulated and permitted by HIPAA, such as disclosures for purposes of Payment or Healthcare Operations and which involve the creation, use or disclosure of PHI.

   **Examples of a Business Associate may include:**
   
   - A vendor who provides billing or collection services for UAMS.
   - A consultant to review the accuracy of billing and coding practices.
A company who provides document shredding services to UAMS for the purpose of shredding documents containing PHI.

An attorney who assists in assessing UAMS’ compliance with federal billing laws and regulations, who is hired in connection with allegations of malpractice, or who advises a hospital on medical staff disciplinary matters.

A person who provides medical transcription services for UAMS.

3. NO BUSINESS ASSOCIATE RELATIONSHIP. The following situations are examples of situations where a Business Associate relationship is not created:

1. **Provider to Provider.** Disclosures of PHI between UAMS and a health care provider outside of UAMS for the purpose of patient treatment, including a physician or hospital laboratory disclosing PHI to an outside laboratory to diagnose an individual.

2. **Service or Maintenance Vendors Without Exposure to PHI.** Relationships with persons or organizations, such as janitorial services, electricians, or copier repair companies, whose functions or services are not intended to involve the use or disclosure of PHI, and where any disclosure of PHI during the performance of their duties would be limited and incidental, such as disclosures that may occur while walking through or working in file rooms. **NOTE:** If a service is hired to do work for UAMS where disclosure of PHI is not limited in nature (such as routine handling of records or shredding of documents containing protected health information), it likely would be a Business Associate.

3. **Couriers.** Disclosures of PHI by UAMS to a person or organization that acts merely as a conduit for protected health information, such as the U.S. Postal Service, UPS, Federal Express, other private couriers, and their electronic equivalents.

4. **OHCA.** Disclosures of PHI between UAMS and other covered entities with whom UAMS participates in an OHCA where the PHI relates to the joint health care activities of the OHCA.

5. **Financial Transaction Institutions.** When a financial institution processes consumer-conducted financial transactions by debit, credit, or other payment card, clears checks, initiates or processes electronic funds transfers, or conducts any other activity that directly facilitates or effects the transfer of funds for payment for health care or health plan premiums. When it conducts these activities, the financial institution is providing its normal banking or other financial transaction services to its customers; it is not performing a function or activity for, or on behalf of, UAMS.

6. **No PHI Disclosed.** If the information disclosed is not PHI, or if the PHI is de-identified in accordance with the UAMS De-Identification of Protected Health Information and Limited Data Set Information Policy 3.1.31, then the person or entity receiving the information would not be a “Business Associate.”

C. **DISCLOSURES TO A BUSINESS ASSOCIATE:** UAMS may not disclose PHI to a Business Associate or allow a Business Associate to create or receive PHI on behalf of UAMS until UAMS obtains satisfactory assurance that the Business Associate will appropriately safeguard the information as required by the HIPAA regulations. This satisfactory assurance must be documented in writing in the form of a contract, agreement or other written arrangement, and must also include the obligations of UAMS with regard to the PHI to be held by the Business Associate.

D. **DISCLOSURES TO BUSINESS ASSOCIATE OF ANOTHER.** UAMS may share PHI directly with the
E. **DISCLOSE ONLY MINIMUM NECESSARY.** UAMS will disclose to a Business Associate only the PHI that is reasonably necessary to accomplish the intended purpose of the disclosure. See UAMS *Minimum Necessary Policy 3.1.25* for more information. Under a Business Associate Agreement, the Business Associate must request only the information that is the “minimum necessary”, and therefore, UAMS may reasonably rely on a request from a Business Associate, or the Business Associate or another, to be a request for PHI that meets the minimum necessary standards.

F. **DISCLOSURES THROUGH A LIMITED DATA SET – NO BUSINESS ASSOCIATE AGREEMENT REQUIRED.** When UAMS discloses information to a Business Associate through the use of a “Limited Data Set” (where most of the PHI is de-identified so that the patient’s identity cannot be determined) pursuant to the UAMS *De-Identification of Protected Health Information and Limited Data Set Information Policy 3.1.31*, a Business Associate Agreement is not required. Only a Data Use Agreement is required.

G. **DISCLOSURES FOR PURPOSES OF RESEARCH.** See UAMS *Research Policy 3.1.27*.

H. **DATA AGGREGATION SERVICES.** “Data Aggregation Service” means the combining of PHI of one covered entity, such as UAMS, with the PHI of another covered entity, such as another hospital. When the Data Aggregation Service is performed by the Business Associate of both covered entities to permit data analyses relating to the Healthcare Operations of the respective covered entities, this is a disclosure of PHI that is permitted by HIPAA. In the absence of the Business Associate arrangement involving Data Aggregation Services, the ability of the participating covered entities, such as two hospitals, to share the PHI with one another would be restricted under HIPAA.

I. **BUSINESS ASSOCIATE AGREEMENTS:** If the person or entity meets the definition of a “Business Associate,” a contract or other written arrangement is required to document the assurances from the Business Associate that the Business Associate will appropriately safeguard the Protected Health information it receives or creates on behalf of UAMS. This contract or other written arrangement will be referred to in this Policy as the “Business Associate Agreement.”

1. **Agreement Must Establish Permitted/Required Uses and Disclosures.** The Business Associate Agreement between UAMS and a Business Associate must establish the permitted and required uses and disclosures of PHI by the Business Associate on behalf of UAMS.

2. **Agreement Must Prohibit Use and Further Disclosures in Violation of HIPAA.** UAMS will not authorize a Business Associate to use or further disclose PHI in a manner that would violate the HIPAA privacy Regulations if such use or disclosure were done by UAMS.

3. **Agreement Must Authorize Termination of Contract if Violations by Business Associates.** The Business Associate Agreement between UAMS and a Business Associate must authorize UAMS to terminate the contract if UAMS determines that the Business Associate has violated a material term of the contract.

4. **Other Required Provisions:** In its Business Associate Agreement contract with a Business Associate, UAMS must provide that the Business Associate will:
   a. Not use or further disclose PHI other than as permitted or required by the contract or as required by law;
   b. Use appropriate safeguards to prevent use or disclosure of the PHI other than as provided for by its contract;
   c. Report to UAMS any use or disclosure of PHI not provided for by its contract of which the Business Associate becomes aware;
d. Ensure that any agents, including a subcontractor, to whom it provides PHI received from, or created or received by the Business Associate on behalf of, UAMS agrees to the same restrictions and conditions that apply to the Business Associate with respect to such information;

e. Make any PHI available to UAMS to allow UAMS to comply with HIPAA regulations requiring an individual with access to, or a copy of, the individual’s PHI contained in a Designated Record Set;

f. Make any PHI available to UAMS necessary for UAMS to amend the PHI and incorporate any amendments to the PHI in accordance with HIPAA regulations if UAMS has agreed to or required such amendment;

g. Make available to UAMS the information required to provide an accounting of disclosures in accordance with the HIPAA regulations;

h. Make its internal practices, books, and records, relating to the use and disclosure of Protected Health Information received from UAMS, or created or received by the Business Associate on behalf of UAMS, available to UAMS or to the Secretary of the United States Department of Health and Human Services; and

i. Upon termination of its contract with UAMS, return or destroy all PHI received from UAMS, or created or received by Business Associate on behalf of UAMS, that the Business Associate still maintains in any form and retain no copies of such information; or, if such return or destruction is not feasible, the obligations of the Business Associate contained in the Business Associate Agreement shall extend beyond termination of the contract for so long as the Business Associate maintains such PHI.

5. Agreement May Permit Other Uses. The Business Associate Agreement may permit the Business Associate to use PHI received by the Business Associate in its capacity as a Business Associate to UAMS, only if such use is necessary for (a) the proper management and administration of the Business Associate; or (b) to carry out the legal responsibilities of the business associate.

6. Agreement May Permit Other Disclosures: The Business Associate Agreement may permit the Business Associate to disclose PHI received by the Business Associate in its capacity as a Business Associate to UAMS, ONLY if such disclosure is necessary for (a) the proper management and administration of the Business Associate; or (b) to carry out the legal responsibilities of the business associate; however, prior to either type of disclosure, the following must occur:

   The Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will be held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

7. Agreement May Permit Data Aggregation Services. In its Business Associate Agreement with a Business Associate, UAMS may permit the Business Associate to provide Data Aggregation Services relating to the Healthcare Operations of UAMS.

J. NON-COMPLIANCE BY BUSINESS ASSOCIATE: If UAMS has actual knowledge of a pattern of activity or practice of the Business Associate that constitutes a material breach or violation of the an obligation of the Business Associate under the Business Associate Agreement or other written contract evidencing the Business Associate Agreement, UAMS must take reasonable steps to cure the breach or end the violation, as applicable, and if such steps are unsuccessful, UAMS must:

1. terminate the contract or arrangement with the Business Associate, if feasible; or if termination is not feasible, report the problem to the Secretary of the United States Department Health and Human
2. mitigate, to the extent practicable, any harm effect that is known to UAMS arising from a disclosure of PHI in violation of the UAMS policies and procedures or the HIPAA regulations.

K. TRANSITION PERIOD FOR EXISTING CONTRACTS.

For the persons or entities who meet the definition of a Business Associate of UAMS and who had an existing contract or other agreement with UAMS prior to October 15, 2002, UAMS may continue to operate under that contract until April 14, 2004, or until the contract is renewed or modified, whichever is sooner. This includes contracts that renew automatically without any change in terms or other action by the parties and that exist by October 15, 2002. Renewal or modification requires action by the parties involved. For example, an automatic inflation adjustment to the price of a contract does not trigger the end of the transition period, nor make the contract ineligible for the transition period if the adjustment occurs before April 14, 2003.

This transition period applies only to written contracts or other written arrangements. Oral contracts or other arrangements are not eligible for the transition period.

During the transition period, UAMS may only disclose PHI to a Business Associate for a purpose permitted by the HIPAA Privacy Regulations, and UAMS must apply the minimum necessary standard, as appropriate, to such disclosures. However, UAMS is not required to obtain a Business Associate Agreement during this period.

During the transition period, UAMS must ensure, in whatever reasonable manner deemed effective by UAMS, the appropriate cooperation by its Business Associates in meeting the following requirements during the transition period:

a. Make information available to the Secretary, including information held by a business associate, as necessary for the Secretary to determine compliance by the covered entity.

b. Fulfill a patient’s rights to access and amend his or her PHI contained in a Designated Record Set, including information held by a Business Associate, if appropriate, and receive an accounting of disclosures by a Business Associate.

c. Mitigate, to the extent practicable, any harmful effect that is known to UAMS of an impermissible use or disclosure of PHI by its Business Associate.

d. Covered entities are required to ensure, in whatever reasonable manner deemed effective by the covered entity, the appropriate cooperation by their business associates in meeting these requirements during the transition period.

L. AUTHORITY TO SIGN BUSINESS ASSOCIATE AGREEMENTS: All Business Associate Agreements, or other written contracts evidencing the Business Associate Agreement, must be signed by the UAMS Chief Financial Officer, the UAMS Director of Contract Services, the UAMS Director of Procurement Services, or their designee, whichever is applicable. Applicable signature authority will be determined based upon type of underlying agreement.

All Business Associate Agreements entered in connection with activities of any of the UAMS Area Health Educations Centers (AHECs) also may be signed by the UAMS Executive Director or Associate director of the UAMS AHEC Program.

An original of the executed Agreement should be provided to the UAMS Contract Services Office or Procurement Services Office for the purpose of maintaining a log of all Business Associate Agreements entered into by UAMS.

NO UAMS EMPLOYEE, FACULTY OR STAFF MEMBER IS AUTHORIZED TO EXECUTE A UAMS
BUSINESS ASSOCIATE AGREEMENT, OTHER THAN THOSE INDIVIDUALS LISTED ABOVE.
UAMS ADMINISTRATIVE GUIDE

NUMBER: 3.1.15
DATE: 03/05/2002
REVISION: 08/15/2005

SECTION: ADMINISTRATION
AREA: GENERAL ADMINISTRATION
SUBJECT: CONFIDENTIALITY POLICY

SCOPE

UAMS physicians, faculty, employees, students, contract personnel, vendors, volunteers, and official visitors.

DEFINITIONS

Confidential Information includes information concerning UAMS research projects, confidential employee information, information concerning the UAMS research programs, proprietary information of UAMS, and sign-on and password codes for access to UAMS computer systems. Confidential information shall include Protected Health Information.

Protected Health Information (PHI) means information that is part of an individual’s health information that identifies the individual or there is a reasonable basis to believe the information could be used to identify the individual, including demographic information, and that (i) relates to the past, present or future physical or mental health or condition of the individual; (ii) relates to the provision of health care services to the individual; or (iii) relates to the past, present, or future payment for the provision of health care services to an individual. This includes PHI which is recorded or transmitted in any form or medium (verbally, or in writing, or electronically). PHI excludes health information maintained in educational records covered by the federal Family Educational Rights Privacy Act and health information about UAMS employees maintained by UAMS in its role as an employer.

To access any other terms or definitions referenced in this policy: http://hipaa.uams.edu/DEFINITIONS%20-%20HIPAA.pdf

POLICY

UAMS prohibits the unlawful or unauthorized access, use or disclosure of confidential and proprietary information obtained during the course of employment or other relationship with UAMS. As a condition of employment, continued employment or relationship with UAMS, UAMS workforce shall be required to sign the UAMS Confidentiality Agreement approved by the UAMS Office of General Counsel. UAMS will provide training for each of its workforce members on the importance of maintaining confidentiality and the specific requirements of state and federal law, including the HIPAA Privacy Regulations and laws protecting the privacy of students and employees.

This policy applies to information maintained or transmitted in any form, including verbally, in writing, or in any electronic form.

PROCEDURES:

1. Confidentiality Agreement: As a condition of employment, continued employment, or a relationship with UAMS, UAMS will require such individuals to sign the UAMS Confidentiality Agreement approved by the UAMS Office of General Counsel. The Confidentiality Agreement shall include an agreement that the signing party will abide by the UAMS policies and procedures and with federal and state laws, governing the confidentiality and privacy of information.
All new employees, students, or vendors requiring access to electronic Confidential Information (computer systems) must have a current Confidentiality Agreement on file in the IT Security Office. The UAMS IT Security Office will maintain signed Confidentiality Agreements and furnish a copy to the individual signing the agreement. It is the responsibility of the manager hiring individual vendors or consultants or receiving sales representatives or service technicians (who do not require electronic access but who may have access to Confidential Information) to require execution of the appropriate confidentiality agreements approved by the UAMS Office of General Counsel and to send those documents to the UAMS IT Security Office.

2. **Restriction on Access, Use and Disclosure of Confidential Information:** UAMS limits and restricts access to Confidential Information and computer systems containing Confidential Information based upon the specific duties and functions of the individual seeking or requiring access. UAMS will restrict access to Confidential Information to the minimum necessary to perform individual job functions or duties. UAMS will further limit and control access to its computer systems with the use of sign-on and password codes issued by the IT Security Office to the individual user authorized to have such access.

Authorization to access, use or disclose Protected Health Information also is governed by the UAMS Use and Disclosure Policy. UAMS will control and monitor access to Confidential Information through management oversight, identification and authentication procedures, and internal audits. UAMS managers and heads of departments will have the responsibility of educating their respective staff members about this Policy and the restrictions on the access, use and disclosure of Confidential Information, and will monitor compliance with this Policy.

3. **Sales Representatives and Service Technicians:** Must register in the appropriate area (Refer to UAMS Guidelines for Vendors and Sales Representatives Policy), sign and complete the Confidentiality Agreement prior to any exposure to UAMS Confidential Information.

4. **Media:** All contacts from the media regarding any Confidential Information must be referred to the UAMS Office of Communications and Marketing (501-686-8998 or pager 501-395-5989)

5. **Violation of Confidentiality Policy:** Individuals shall not access, use, or disclose Confidential Information in violation of the law or contrary to UAMS policies. Each individual allowed by UAMS to have access to Confidential Information must maintain and protect against the unauthorized access, use or disclosure of Confidential Information. Any access, use or disclosure of Confidential Information in any form – verbal, written, or electronic – which is inconsistent with or in violation of this Policy may result in disciplinary action, including but not limited to, immediate termination of employment, dismissal from an academic program, loss of privileges, or termination of relationship with UAMS.

All UAMS employees and others subject to this Policy must report any known or suspected incidents of access, use or disclosure of Confidential Information in violation of this Policy or in violation of the law.

**CONFIDENTIALITY AGREEMENT**

As a condition of my employment, continued employment or relationship with UAMS, I agree to abide by the requirements of the UAMS Confidentiality Policy and with federal and state laws governing confidentiality of a patient’s Protected Health Information, and I agree to the terms of this Confidentiality Agreement.

I understand and agree that if I access, use or disclose Confidential Information in any form – verbal, written, or electronic – in a manner that is inconsistent with or in violation of the Confidentiality Policy, UAMS may impose disciplinary action, including but not limited to, immediate termination of employment, dismissal from an academic program, loss of privileges, or termination of relationship with UAMS.

I understand that when I receive a sign-on code to access the UAMS Network and Systems, I have agreed to the following terms and conditions:
The sign-on and password codes assigned to me are equivalent to my signature, and I will not share the passwords with anyone.

I will be responsible for any use or misuse of my network or application system sign-on codes.

I will not attempt to access information on the UAMS Network and Systems except to meet needs specific to my job or position at UAMS.

I acknowledge that I have read the terms of this Confidentiality Agreement, and that I have received a copy.

_________________________________________ SS# __________________________

(Signature)

Print Full Name: _______________________________________________________

Date: ___________________________ Department: ___________________________

Witness at UAMS Orientation only, otherwise not required: ___________________

_________________________ Date: ___________________________

Supervisor/Manager’s Signature: ___________________________ Date: _____________

(If Vendor, then Department Head Signature required)

_________________________ Date: ___________________________

Department Head Signature: ___________________________

(Please return completed form to UAMS IT Security Office, #802)
FOR NON-UAMS EMPLOYEES, VENDORS & CONSULTANTS ONLY

Please provide the following additional information:

1. UAMS Sponsor Name/Title: __________________________________________
   Department: ______________________________________________________

2. What type of access is needed: ______________ On-Site ______ Remote
   Describe: _________________________________________________________

3. Please describe why the access is needed: ____________________________
   __________________________________________________________________
   __________________________________________________________________
UAMS ADMINISTRATIVE GUIDE

NUMBER: 3.1.39
DATE: 11/01/03
REVISION: 03/01/04

SECTION: ADMINISTRATION
AREA: GENERAL ADMINISTRATION
SUBJECT: CREATION or REVISION of UAMS POLICIES INVOLVING HIPAA ADMINISTRATIVE, SECURITY or PRIVACY REQUIREMENTS

SCOPE

UAMS Workforce

PURPOSE

To establish a system to review, prior to the final approval and publication, UAMS policies developed or revised after April 14, 2003 which involve, impact or affect the administrative, security and privacy requirements of HIPAA.

DEFINITIONS

For purposes of this policy, the following definitions apply:


Disclosure means the release, transfer, provision of access to, or divulging of information in any manner (verbally or in writing) by UAMS to persons who are not UAMS employees or students, or to any other person or entity OUTSIDE of UAMS.

Protected Health Information (PHI) means information that is part of an individual’s health information that identifies the individual or there is a reasonable basis to believe the information could be used to identify the individual, including demographic information, and that (i) relates to the past, present or future physical or mental health or condition of the individual; (ii) relates to the provision of health care services to the individual; or (iii) relates to the past, present, or future payment for the provision of health care services to an individual.
individual.  This includes PHI which is recorded or transmitted in any form or medium (verbally, or in writing, or electronically). PHI excludes health information maintained in educational records covered by the federal Family Educational Rights Privacy Act and health information about UAMS employees maintained by UAMS in its role as an employer.

**UAMS Workforce** means for purposes of this Policy, physicians, employees, volunteers, trainees, visiting faculty, and other persons whose conduct, in the performance of work for UAMS, are under the direct control of UAMS, whether or not they are paid by UAMS.

**POLICY**

Prior to final approval and publication of any policies which involve, impact or affect the requirements of HIPAA, such policies shall be submitted for review to the UAMS HIPAA Office. The UAMS HIPAA Office shall make any revisions necessary to ensure compliance with the HIPAA regulations and to maintain consistency with other UAMS policies concerning the requirements of HIPAA.

**PROCEDURE**

A. **In General – For All Policies:**

1. When creating, developing or revising any UAMS policy, the person or committee in charge of creating, developing or revising such a policy must determine whether the policy has the potential to involve, impact or affect a requirement of HIPAA, including both the Security and Privacy aspects of HIPAA. HIPAA regulates, for example, the disclosure of PHI; restrictions on disclosure of PHI; confidentiality of PHI; access to PHI; restriction of access to PHI; use of PHI for marketing, fundraising or research purposes; physical and technical safeguarding of PHI; and protection of the integrity and confidentiality of electronically stored PHI.

2. If the policy has the potential to involve, affect or impact a requirement of HIPAA, or if the person or committee in charge of the policy is unsure whether the policy has the potential to involve, affect or impact a requirement of HIPAA, the policy must be submitted to the UAMS HIPAA Office for review prior to the final approval and publication of the policy.

3. The UAMS HIPAA Office will review the proposed policy and make the revisions necessary to ensure compliance with the HIPAA regulations, and any other security or
privacy laws at issue. If revisions are made by the HIPAA Office, the HIPAA Office will provide the revisions to the appropriate person or chair of the committee submitting the policy. After coordinated review between the HIPAA Office and the originators of the policy to discuss any revisions, the HIPAA Office will forward the final policy to the Office of Vice Chancellor for Finance or other appropriate areas or individuals responsible for publishing the particular policy at issue. A copy of the final policy will be provided to the originators of the policy. The HIPAA Office will include a signed Acknowledgment indicating that the policy has been reviewed by the HIPAA Office and whether revisions were made to the policy.

4. If the Acknowledgment by the UAMS HIPAA Office is not included with the HIPAA-related policy sent to the Office of Vice Chancellor for Finance, the Office of Vice Chancellor for Finance must forward the policy to the UAMS HIPAA Office for review and completion of the Acknowledgment form before the policy can be published.

B. Medical Center Policies:

For policies created, developed or revised for the UAMS Medical Center and submitted to the Hospital Compliance Office for approval, the Hospital Compliance Office shall forward the policies to the UAMS HIPAA Office if the Hospital Compliance Office determines that the policy has or may have the potential to involve, affect or impact a requirement of HIPAA. If the Hospital Compliance Office submitted the proposed policy for review by the UAMS HIPAA Office, a completed and signed Acknowledgment form from the HIPAA Office must be included with the policy before the policy can be published in the UAMS Medical Center policies.

C. College Policies:

For policies created, developed or revised for the UAMS Colleges, such as the College of Medicine, College of Pharmacy, College of Nursing, College of Health Related Professions, and all other UAMS Colleges, policies shall be forwarded to the UAMS HIPAA Office if the College determines that the policy has the potential to involve, affect or impact a requirement of HIPAA. If the College submitted the proposed policy for review by the UAMS HIPAA Office, a completed and signed Acknowledgment form from the HIPAA Office must be included with the policy before the policy can be published.

D. Office of Research Policies:

For policies created, developed or revised for research purposes and submitted to the UAMS Office for Research and Sponsored Programs for approval, the Research Privacy Officer shall forward the policies to the UAMS HIPAA Office if the Research Privacy Officer determines that the policy has or may have the potential to involve, affect or impact a requirement of HIPAA.
the Research Privacy Officer submitted the proposed policy for review by the UAMS HIPAA Office, a completed and signed Acknowledgment form from the HIPAA Office must be included with the policy before the policy can be published.

E. All Other UAMS Department Policies:

For policies created, developed or revised for all other UAMS Departments, including, but not limited to, the Area Health Education Centers (AHECs), the IT Department, the Office of Human Resources, the Purchasing Office, Business Development and Managed Care, these policies shall be forwarded to the UAMS HIPAA Office if the Department determines that the policy has the potential to involve, affect or impact a requirement of HIPAA. If the Department submitted the proposed policy for review by the UAMS HIPAA Office, a completed and signed Acknowledgment form from the HIPAA Office must be included with the policy before the policy can be published.

F. Acknowledgement:

An example of the Acknowledgment form is included with this policy.
UAMS ADMINISTRATIVE GUIDE

NUMBER: 3.1.31
DATE: 04/01/03
REVISION: 03/01/04

SECTION: ADMINISTRATION
AREA: GENERAL ADMINISTRATION
SUBJECT: DE-IDENTIFICATION OF PROTECTED HEALTH INFORMATION AND LIMITED DATA SET INFORMATION

SCOPE

UAMS Workforce

DEFINITIONS

_Data Use Agreement_ means a written agreement between UAMS and a recipient of Limited Data Set information which establishes the permitted uses and disclosures of such information and certain administrative safeguards to protect the information. The standard UAMS Data Use Agreement is attached to the UAMS _Research Policy, 3.1.27_.

_De-Identified Protected Health Information_ is any information about a patient that does not identify the patient and with respect to which there is no reasonable basis to believe that the information can be used to identify the patient.

_Disclosure_ means the release, transfer, provision of access to, or divulging of information in any manner (verbally or in writing) by UAMS to persons who are not UAMS employees or students, or to any other person or entity _OUTSIDE_ of UAMS.

_Healthcare Operations_ is defined by the HIPAA regulations under 45 C.F.R. § 164.501 and is incorporated herein by reference, and includes the following:

1. Quality assessment and improvement, including outcomes evaluation and development of clinic guidelines; population-based activities relating to improving health, protocol development, case management and case coordination, contacting providers and patients with information about treatment alternatives; and related functions that do not include treatment.
2. Accreditation, certification, licensing or credentialing activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs in which students, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as health care providers, training of non-health care professionals.
3. Conducting or arranging for medical review, legal services and auditing.
4. Business planning and development related to managing and operating the entity.
5. Business management and general administrative activities, such as fundraising and marketing of services to the extent permitted without authorization, disclosure of PHI in a due diligence review or to resolve internal grievances, and customer service.

_Limited Data Set_ means Protected Health Information that excludes the following information about the patient and about relatives, employers, or household members of the patient:
- Names;
- Postal address information, other than town and city, state and zip code;
- Telephone numbers;
- Fax numbers;
- Electronic mail address;
- Social Security numbers;
- Medical Record numbers;
- Health Plan beneficiary numbers;
- Account numbers;
- Certificate/license numbers;
- Vehicle identifiers and serial numbers, including license plate numbers;
- Device identifiers and serial numbers;
- Web Universal Resource Locators (URLs);
- Internet Protocol (IP) address numbers;
- Biometric identifiers, including voice and finger prints; and
- Full face photographic images and any comparable images.

**Protected Health Information (PHI)** means information that is part of an individual’s health information that identifies the individual or there is a reasonable basis to believe the information could be used to identify the individual, including demographic information, and that (i) relates to the past, present or future physical or mental health or condition of the individual; (ii) relates to the provision of health care services to the individual; or (iii) relates to the past, present, or future payment for the provision of health care services to an individual. This includes PHI which is recorded or transmitted in any form or medium (verbally, or in writing, or electronically). PHI excludes health information maintained in educational records covered by the federal Family Educational Rights Privacy Act and health information about UAMS employees maintained by UAMS in its role as an employer.

**UAMS Workforce** means for purposes of this Policy, physicians, employees, volunteers, trainees, and other persons whose conduct, in the performance of work for UAMS, are under the direct control of UAMS, whether or not they are paid by UAMS.

**POLICY**

UAMS may use Protected Health Information (PHI) to create De-Identified PHI. UAMS may disclose PHI to a Business Associate with whom UAMS has a Business Associate Agreement to create De-Identified PHI. De-Identified information is exempt from the requirements of the HIPAA regulations and may be disclosed to others. UAMS will determine that PHI has been De-Identified in accordance with the Procedures set forth in this Policy and consistent with the HIPAA regulations. This Policy is not intended to address De-Identified information that may be subject to IRB regulations or other applicable laws.
PROCEDURE

UAMS may determine that information about a patient has been “de-identified” so that the information is NOT individually identifiable health information, only if:

A. A person with appropriate knowledge and experience with generally accepted statistical and scientific principles and methods for rendering information not individually identifiable determines that the risk is very small that the information could be used alone or in combination with other reasonably available information, by an anticipated recipient to identify an individual who is subject of the information and documents the methods and results of the analysis that justify the determination; or

B. The following identifiers of the patient and the patient’s relatives, employers, or household members of the individual are removed:

- Names
- Geographic subdivisions smaller than a state
- All elements of dates (except year) for dates directly related to an individual, including birth date, admission date, discharge date, date of death; and all ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of 90 or older;
- Telephone and Fax numbers
- E-Mail, IP, and URL addresses
- Social Security Numbers
- Medical Record Numbers
- Health Plan Beneficiary Numbers
- Account Numbers
- Certificate/license Numbers
- Vehicle Identifiers and Serial Numbers, including license plate numbers
- Device Identifiers & Serial Numbers
- Biometric Identifiers, including finger and voice prints
- Full Face or other comparable photographic images
- Any other unique identifying number, characteristic, or code.

C. The first 3 digits of a zip code can be retained if publicly available data from the Bureau of the Census indicates that the geographic unit formed by combining all zip codes with the same three initial digits contains more than 20,000 people, and the initial three digits of a zip code of all such geographic units containing 20,000 or fewer people is changed to 000. The restricted three digit zip codes that must be changed to 000 are: 036, 059, 063, 102, 203, 556, 692, 790, 821, 823, 830, 831, 878, 879, 884, 890, 893, and future ZIP codes that may be added at a later date.

D. After removing the identifiers, the information cannot be released if the UAMS employee has actual
E. **Limited Data Set Information.** Prior patient Authorization is not required for the use or disclosure of “Limited Data Set” information as defined in this Policy, as long as a Data Use Agreement is entered with the recipient of the information and the use or disclosure is for one of the following purposes:

1. For the purposes of research; or

2. For the purposes of public health activities (not already allowed under HIPAA and the UAMS Use and Disclosure Policy), such as disease registries maintained by UAMS, private organizations, other universities, or other types of studies undertaken by the private sector or nonprofit organizations for public health purposes; or

3. For the purposes of UAMS Health Care Operations as defined in this Policy and under the HIPAA regulations.

UAMS *Use and Disclosure of PHI and Medical Records Policy, 3.1.28*

START HERE—[DE IDENTIFICATION FLOW CHART](http://uams.edu/AdminGuide/Win03131.html) (pdf format)
UAMS Workforce

DEFINITIONS

UAMS Workforce means employees physicians, volunteers, residents, students, trainees, visiting faculty, and other persons whose conduct, in the performance of work for UAMS, is under the direct control of UAMS, whether or not they are paid by UAMS.

POLICY

UAMS will provide to all UAMS Workforce the appropriate education and training necessary to comply with the HIPAA Regulations, and the UAMS HIPAA-related policies and procedures related to the individual’s role and specific job duties at UAMS. See HIPAA Training Matrix Materials for the mandatory HIPAA training must be approved by the UAMS HIPAA Office.

PROCEDURE

All HIPAA training completed by any of these individuals will be recorded in the UAMS Training Tracker System or manually maintained by the UAMS office assigned to the specific training.

A. General HIPAA Training: All Physicians and other Healthcare Professionals with FGP or AHEC provider billing numbers, Fellows and Residents must complete the HCCS HIPAA Intranet Training Module within sixty (60) days of their appointment date. User IDs and Passwords for this training may be obtained by contacting the FGP Compliance Office at (501) 603-1219.

All employees who attend New Employee Orientation will receive HIPAA training, at that time. Employees will be required to sign an Attestation establishing that the employee completed the required training program.

Employees also receive an explanation letter and Attestation on HIPAA policies and procedures with instructions to present to their manager or supervisor for additional training in policies and procedures.

All other employees of UAMS who do not attend Orientation must complete an officially sanctioned UAMS HIPAA training program. Employees are required to sign an attestation establishing that the employee completed the required training program within 30 days of hire date.

All UAMS students will receive HIPAA training instructions as part of Orientation. A completed Review and Acknowledgment of Completion must be signed and returned to the UAMS HIPAA Office #829 within 2 weeks after Orientation.

All Volunteers sponsored by UAMS will receive HIPAA training coordinated through the appropriate Office of
Volunteers and approved by the UAMS HIPAA Office.

All UAMS Official Visitors will receive HIPAA training. The UAMS Sponsor of the Visitor must provide HIPAA training materials and obtain a signed UAMS Confidentiality Agreement from the Visitor.

For all other persons, including affiliated students, refer to the [HIPAA Training Matrix](http://www.uams.edu/orc/Training/Training.htm)

**B. Research HIPAA Training:** UAMS workforce working with human subjects for research purposes should complete the HIPAA research training along with the IRB Human Subjects Training. [http://www.uams.edu/orc/Training/Training.htm](http://www.uams.edu/orc/Training/Training.htm) This includes the principal investigator, co-investigators and research staff including, but not limited to, research associates, research assistants and study coordinators.

**C. HIPAA Related Policy and Procedures Training:** It is the responsibility of the individual’s supervisor to provide employee training on UAMS HIPAA-related policies and procedures specific to their role. An attestation is required.
SCOPE

All UAMS physicians, faculty, employees and students or other UAMS Workforce members performing research on human subjects (living or deceased), or conducting reviews of Protected Health Information preparatory to research. For research conducted by UAMS workforce members in a non-UAMS physical location, such as Arkansas Children’s Hospital, the policies of that institution will apply.

DEFINITIONS

For purposes of this Policy, the following definitions apply:

Database means the compilation of data in any form and maintained in any fashion, and includes, but is not limited to, spreadsheets, tables, or other data repositories maintained in any form. This list is not intended to be all inclusive but, rather, a guideline.

Data Use Agreement is a written agreement between UAMS and the Limited Data Set recipient which establishes the permitted uses and disclosures of such information and certain administrative safeguards to protect the information.

De-Identified Information means information which does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual. UAMS may determine that health information is De-Identified if the following identifiers of the individual or of relatives, employers, or household members of the individual, are removed, and UAMS does not have actual knowledge that the information could be used alone or in combination with other information to identify an individual who is the subject of the information:

- Names;
- All geographic subdivisions small than a state, including street address, city, county, precinct, and ZIP Code;
- All elements of dates (except year) for dates directly related to an individual, including birth date, admission date, discharge date, date of death; and all ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of 90 or older;
- Telephone numbers;
- Fax numbers;
- Electronic mail address;
- Social Security numbers;
• Medical Record numbers;
• Health Plan beneficiary numbers;
• Account numbers;
• Certificate/license numbers;
• Vehicle identifiers and serial numbers, including license plate numbers;
• Device identifiers and serial numbers;
• Web Universal Resource Locators (URLs);
• Internet Protocol (IP) address numbers;
• Biometric identifiers, including voice and finger prints; and
• Full face photographic images and any comparable images.

**Designated Record Set** means, for purposes of Research, medical records about individuals used, in whole or in part, by or for UAMS to make treatment decisions about individuals, including any treatment information generated in the research context.

**Disclosure** means the release, transfer, provision of access to, or divulging of information in any manner (verbally or in writing) to persons or entities **OUTSIDE** of UAMS.

**Limited Data Set means** information that excludes the following direct identifiers of the individual **and of relatives, employers, or household members** of the individual:

- Names;
- Street or Postal address information (*other than* town, city, State and zip code);
- Telephone numbers;
- Fax numbers;
- Electronic mail address;
- Social Security numbers;
- Medical Record numbers;
- Health Plan beneficiary numbers;
- Account numbers;
- Certificate/license numbers;
- Vehicle identifiers and serial numbers, including license plate numbers;
• Device identifiers and serial numbers;
• Web Universal Resource Locators (URLs);
• Internet Protocol (IP) address numbers;
• Biometric identifiers, including voice and finger prints; and
• Full face photographic images and any comparable images.

Pre-Research or Review Preparatory to Research means the review of information or records prior to obtaining patient authorization and consent or prior to obtaining an IRB Waiver of Authorization in which the review is solely to prepare a research protocol, to determine if a research project is feasible, or for similar purposes preparatory to research.

Principal Investigator (PI) or Investigator shall mean the UAMS Principal Investigator, researcher or the research team or study coordinators collectively.

Protected Health Information (PHI) means information that is part of an individual’s health information that identifies the individual or there is a reasonable basis to believe the information could be used to identify the individual, including demographic information, and that (i) relates to the past, present or future physical or mental health or condition of the individual; (ii) relates to the provision of health care services to the individual; or (iii) relates to the past, present, or future payment for the provision of health care services to an individual. This includes PHI which is recorded or transmitted in any form or medium (verbally, or in writing, or electronically). PHI excludes health information maintained in educational records covered by the federal Family Educational Rights Privacy Act and health information about UAMS employees maintained by UAMS in its role as an employer.

Research shall mean any research or systematic investigation on living or deceased human subjects (retrospective or prospective) seeking the use of PHI, including research development, testing, and evaluation, designed to contribute to generalizable knowledge. This includes research that is consistent with what the IRB currently reviews under the Common Rule.

Workforce means UAMS physicians, faculty, employees, trainees, students, volunteers and other persons who conduct, in the performance of work for UAMS, is under the direct control of UAMS, whether or not they are paid by UAMS.

POLICY

It is the policy of UAMS to protect the privacy and confidentiality of medical records and information contained in the medical records of persons who are subjects of UAMS Research projects as required by law, including any and all Protected Health Information as defined by the HIPAA Privacy Regulations. Protected Health Information of a Research subject, and the use or disclosure of such information, shall be governed by the UAMS Research Policy and any other applicable UAMS policies.

This HIPAA Research Policy is not intended to replace the applicable legal requirements or UAMS policies concerning compliance with professional ethics, the Common Rule, FDA regulations, or other applicable laws and policies. The Principal Investigator (PI) or Project Director (PD) is responsible for obtaining IRB approval for all Research projects that use human subjects including Research projects that propose the use of a Research project’s PHI. The PI must have the approval letter from the IRB before the project can begin. Please see IRB polices and procedures and the applicable regulations at http://www.uams.edu/ora/irb for the regulations and https://aria.uams.edu for submitting a human subjects protocol for review and approval by the IRB.

UAMS Workforce working with human subjects for Research purposes must complete the required HIPAA Research Training along with the IRB Human Subjects Training. http://www.uams.edu/orc/Training/Training.htm. This includes...
PROCEDURES

A. GENERAL: Protected Health Information can be used or disclosed for Research purposes under the following circumstances and only in accordance with this policy:

1. Authorization: The patient or the patient’s Legal Representative has authorized the use or disclosure in accordance with this policy;

2. IRB/Privacy Board Review: An Institutional Review Board (IRB) has approved a Waiver of Authorization;

3. De-Identified Information: The PHI is De-Identified;

4. Limited Data Set: Only Limited Data Set information is used or disclosed, and UAMS enters into a Data Use Agreement with the Limited Data Set recipient prior to disclosure;

5. Pre-Research: UAMS obtains from the researcher representations that the use or disclosure is sought solely to review PHI as necessary to prepare a research protocol or for similar purposes preparatory to research;

6. Deceased Individuals: UAMS obtains from the researcher representations that the use or disclosure is sought solely for research on the PHI of deceased individuals.

B. RESEARCH COVERED BY THIS POLICY

1. This policy applies to all Research by UAMS Workforce that involves the use or disclosure of Protected Health Information regardless of the source of funding of the Research.

2. This policy applies to clinical trials, chart reviews, epidemiological studies, behavioral and social science studies, basic science research studies, and research that involves diagnosing or treating an individual as well as Research that involves neither diagnosis or treatment.

3. This policy applies to all Research activities, which includes, but is not limited to the following:
   - The initial review of PHI for Pre-Research purposes such as to determine the feasibility of a study or to develop a research protocol;
   - Research projects that involve the creation of a Database containing PHI;
   - Research projects that involve the use of PHI from current Research Databases;
   - Research projects that involve the addition of PHI to an existing Research Database;
   - Research projects approved by the IRB that create PHI during the Research project;
   - Research projects approved by the IRB that use existing PHI stored in any form;
   - Recruiting patients to participate in a Research study;
• Enrolling patients into a Research study;
• Research projects with patient/subject authorization and consent;
• Conducting a Research study.

4. This policy applies all UAMS research activities that use or seek to use PHI about humans, regardless of the form in which the PHI is maintained (e.g., hard copy or electronic format).

C. USES or DISCLOSURES OF PHI – In General

1. General Requirements: UAMS will protect the privacy of Research subjects and their PHI collected during a Research project. UAMS will not use or disclose EXISTING PHI or PHI CREATED DURING A RESEARCH PROJECT, unless one of the following circumstances exist:

   a. The subject signs both (1) a HIPAA Authorization for use and disclosure of PHI using the UAMS HIPAA Research Authorization Form or other form containing all the elements of a legally effective HIPAA authorization; AND (2) the informed consent to participate in research form approved by the IRB as required by UAMS policies.

   You must give a copy of the signed Authorization and Informed Consent Forms and the UAMS Notice of Privacy Practices to the research subject. Ask subject to sign Acknowledgment form. See Notice of Privacy Practices Policy 3.1.21

   b. The IRB grants a waiver to the requirement of obtaining a signed HIPAA Research Authorization Form, or

   c. The IRB approved protocol uses properly De-identified PHI, or

   d. The IRB approved protocol uses the Limited Data Set and the recipient (if recipient is not a member of the UAMS workforce) signs a Data Use Agreement with UAMS (or the entity that maintains the Designated Record Set).

2. Minimum Necessary Applies: PHI that is used or disclosed for Research purposes without a HIPAA-compliant Authorization should be limited to the minimum necessary to accomplish the purpose of the Research. Minimum Necessary Policy, 3.1.25.

D. GRANDFATHERING HIPAA RESEARCH AUTHORIZATION – Ongoing Research at Time of April 14, 2003

UAMS may continue to use and disclose PHI created or received before and after April 14, 2003, for Research purposes if UAMS has obtained or received any one of the following prior to April 14, 2003:

• A HIPAA Research Authorization received prior to April 14, 2003, from the patient to use or disclose their PHI for Research purposes; or

• The informed consent of the patient received prior to April 14, 2003, to participate in the Research; or

• An IRB-approved waiver of informed consent for the Research in accordance with the Common Rule and received prior to April 14, 2003.
This includes permissions, consents or waivers that allowed future unspecified Research.

**Exception to Grandfathering – When Authorization Required.** If the protocol was approved by the IRB prior to April 14, 2003, but the protocol required that informed consent and subjects would be enrolled after April 14, 2003, a protocol revision must be submitted to the IRB adding a separate HIPAA-compliant Research Authorization or amending the informed consent to include the elements of a HIPAA-compliant Research Authorization for subjects enrolled after April 14, 2003.

E. **RESEARCH ON INFORMATION OF A DECEASED PERSON**

1. **General Requirements:** A UAMS HIPAA Research Authorization Form is not required when conducting Research of PHI on the deceased. The information requested, however, should be the minimum necessary to accomplish the purposes of the Research. *Minimum Necessary Policy, 3.1.25*

The information requested must be solely for Research on the PHI of decedents and not, for example, for Research of living relatives of decedents. Upon request of UAMS, documentation of the deaths of the study subjects will be provided. No Authorization or alteration or waiver of Authorization by an IRB or Privacy Board is needed for use or disclosure of PHI for Research only on the PHI of deceased persons, if these conditions are met, and the Investigator completes a Certification as described below.

2. **Certification by Investigator:** A Certification by the Investigator is required in which Investigators must certify in writing the following when requesting PHI on deceased individuals: (1) The investigator seeks use and disclosure of PHI for research on deceased individuals; (2) the investigator will provide proof of death if requested; and (3) the investigator seeks PHI solely for Research and nothing else.

For these purposes, PIs will complete and sign a Certification for Use and Disclosure of Protected Health Information of Deceased Individuals Form and present it to the custodian of the records being requested before the custodian can release the PHI to the investigator.

F. **REVIEW PREPARATORY TO RESEARCH:**

1. **Pre-Research or Review Preparatory to Research** means the review of information or records prior to obtaining patient authorization and consent or prior to obtaining an IRB Waiver of Authorization in which the review is solely to prepare a research protocol, to determine if a research project is feasible, or for similar purposes preparatory to research. For example, a review to design a research study, to formulate hypotheses, or to assess the feasibility of conducting a study.

**Note:** Preparatory to Research activities may include activities to identify prospective Research subjects, but it does not include contacting patients, contacting potential subjects, or recruitment of subjects in any manner.

2. **Authorization:** A UAMS HIPAA Research Authorization Form or other HIPAA Authorization form is not required when conducting Pre-Research or Review Preparatory to Research.

3. **Minimum Necessary:** The information requested for review must be the minimum necessary to accomplish the purpose of the Pre-Research. *Minimum Necessary Policy, 3.1.25.* In addition, a Certification by the Investigator is required as described below.

4. **Certification by Investigator Required:** When undertaking “Pre-Research” or a “Review Preparatory to Research,” investigators must have a current written certification on file signed by the investigator that includes the following representations:
a. The PI seeks use or disclosure of PHI solely to review such information as necessary to prepare a Research protocol or similar purposes Preparatory to Research; and

b. PI shall not remove any PHI from UAMS premises in the course of such review; and

c. The use or disclosure of PHI is necessary for Research purposes.

For these purposes, PIs must fill out a Reviews Preparatory to Research Form, (please print from Word File Icon located at the top of this document) attached, and submit it to the custodian of the records being requested before the custodian can release the PHI to the investigator. Annual renewals are required. See Paragraph 5 below.

5. Re-Certification Required: On an annual basis, PIs must re-new their individual certifications regarding Reviews Preparatory to Research.

6. PHI May Not Leave UAMS Premises: PHI that is being reviewed for Pre-Research purposes must not leave the UAMS premises in the course of such review.

G. IRB APPROVAL OF RESEARCH

The Principal Investigator (PI) or Project Director (PD) is responsible for obtaining IRB approval for all Research projects that use human subjects or which otherwise propose the use of an individual’s PHI. The PI must have the approval letter from the IRB before the project can begin. Please see IRB polices and procedures at www.uams.edu/ora/hrac for the regulations and visit https://aria.uams.edu for submitting a human subjects protocol for review and approval by the IRB.

H. REQUIRED HIPAA RESEARCH AUTHORIZATION

1. HIPAA Research Authorization vs. Informed Consent for Research

All Research projects that use or create PHI will require subjects to sign the usual IRB-approved Informed Consent to participate in a Research project, AND a form similar to the UAMS HIPAA Research Authorization Form as attached, as long as the form contains all the elements of a legally effective HIPAA authorization. The IRB will look for the usual Informed Consent AND the additional HIPAA Research Authorization (example UAMS HIPAA Research Authorization Form) as required by this policy as criteria for granting final approval for a Research project. Beginning April 14, 2003, if the legally effective HIPAA authorization elements are not present in projects using or creating PHI, then the IRB will cite this as a minor revision prior to granting final approval.

2. HIPAA Research Authorization Combined with Informed Consent for Research

a. Combination of UAMS HIPAA Research Authorization Form and Informed Consent Form: UAMS prefers, but will not require, the HIPAA Research Authorization to be a form separate from the Informed Consent form. The HIPAA Research Authorization and the Informed Consent may be combined.

b. UAMS HIPAA Research Authorization Form: Example of HIPAA Research Authorization:

PIs and PDs shall use nothing less than the elements of the UAMS HIPAA Research Authorization Form, but may modify it to make it more stringent if the project dictates it. Researchers are encouraged to modify the form relative to their Research project, but are not authorized to delete any of the required elements presented in the form. The authorization form MUST be submitted to the IRB as an update for approval by expedited review.

I. WAIVER OF HIPAA RESEARCH AUTHORIZATION

http://uams.edu/AdminGuide/Win03127.html
1. **Waiver of HIPAA Research Authorization:**

If it would be impracticable to re-consent or obtain a UAMS HIPAA Research Authorization Form to do the research project, then the PI can request a waiver of the additional HIPAA Research Authorization as described by this policy. PIs or PDs must submit their requests for a waiver of authorization to the IRB in writing and must include the following explicit protocol elements for the waiver of authorization to be considered by the IRB:

a. Provide a brief description of the Protected Health Information to be used.

b. Use the following methods to ensure minimal risk to privacy of individuals:
   
   (i) Describe an adequate plan to protect the identifiers from improper use or disclosure.
   
   (ii) Describe an adequate plan to destroy the identifiers at the earliest opportunity consistent with the conduct of Research, unless there is a health or research justification for retaining the identifiers or retentions is required by law.
   
   (iii) Assure the IRB in writing that the PHI will not be re-used or disclosed to any other person or entity, except as required by law, for authorized oversight of the Research project, or for other Research as permitted by the HIPAA regulations.

c. Certify in writing that Research cannot practicably be carried out without the waiver.

d. Certify in writing that Research cannot practicably be conducted without access or use of the PHI.

e. The IRB approval letter MUST contain the following information if a waiver is granted by the IRB:
   
   (i) Name of the IRB and the FWA assurance number.
   
   (ii) Date of action.
   
   (iii) A statement that the IRB determined that the waiver satisfies all the criteria listed above.
   
   (iv) A brief description of the PHI for which use and disclosure has been determined to be necessary for Research by the IRB. (Provided by the PI above).
   
   (v) The type of review administered under the Common Rule.
   
   (vi) Signature of the chair or chair’s designee authorized to sign.

J. **WHEN AUTHORIZATION IS NOT REQUIRED**

1. **HIPAA Research Authorization is NOT Required When Information is De-Identified.**

   a. **De-Identified Information** means information which does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual. UAMS may determine that health information is De-Identified if the following identifiers of the individual and of relatives, employers, or household members of the individual, are removed, and UAMS does not have actual knowledge that the information could be used alone or in combination with other information to identify an individual who is the
subject of the information:

- Names;
- All geographic subdivisions smaller than a state;
- All elements of dates (except year) for dates directly related to an individual, including birth date, admission date, discharge date, date of death; and all ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of 90 or older;
- Telephone numbers;
- Fax numbers;
- Electronic mail address;
- Social Security numbers;
- Medical Record numbers;
- Health Plan beneficiary numbers;
- Account numbers;
- Certificate/license numbers;
- Vehicle identifiers and serial numbers, including license plate numbers;
- Device identifiers and serial numbers;
- Web Universal Resource Locators (URLs);
- Internet Protocol (IP) address numbers;
- Biometric identifiers, including voice and finger prints;
- Full face photographic images and any comparable images; and
- Any other unique identifying number, characteristic or code.

b. Requirements for Use/Disclosure: Prior patient Authorization is not required for the use or disclosure of properly De-Identified information as defined in this Policy. Refer to UAMS De-Identification Policy, 3.1.31 to determine proper de-identification methods. Also refer to UAMS Request for Data Extract Policy, 3.1.29. If the PI or other researcher will receive PHI, prior to its being De-Identified, however, the PI/researcher must submit a research protocol to the IRB that includes a description of the health information sought and an explanation of how the information will be De-Identified.

c. Codes Used to Re-identify the Information. UAMS may assign to, and retain with, the De-Identified Information, a code or other means of record re-identification as long as that code is not derived from or related to the information about the individual and is not otherwise capable of being translated to identify the individual. For example, a social security number would not be a permissible “code.” A randomly assigned re-identification code, however, would be permissible because it would not be related to information about the individual. UAMS may not
2. HIPAA Research Authorization is NOT Required for Use/Disclosure of Limited Data Set Information and As Long As Recipient Signs a Limited Data Set Agreement Prior to Disclosure.

   a. **Limited Data Set** means information that **excludes** the following direct identifiers of the individual **and** of relatives, employers, or household members of the individual:

   - Names;
   - Street or Postal address information (*other than* town, city, State and zip code);
   - Telephone numbers;
   - Fax numbers;
   - Electronic mail address;
   - Social Security numbers;
   - Medical Record numbers;
   - Health Plan beneficiary numbers;
   - Account numbers;
   - Certificate/license numbers;
   - Vehicle identifiers and serial numbers, including license plate numbers;
   - Device identifiers and serial numbers;
   - Web Universal Resource Locators (URLs);
   - Internet Protocol (IP) address numbers;
   - Biometric identifiers, including voice and finger prints; and
   - Full face photographic images and any comparable images.

   **If the information is necessary for the Research, the Limited Data Set **CAN** include:**

   - Geographic identifiers, such as town, city, county, State, and five-digit zip code
     (but not street name, street address, or post office box)
   - All elements of dates
   - Admission dates
   - Discharge dates
b. **Requirements for Use/Disclosure:** Prior patient Authorization is not required for the use or disclosure of “Limited Data Set” information as defined in this Policy, as long as a Data Use Agreement is entered with the recipient of the information if the recipient is not a member of the UAMS Workforce and the use or disclosure is for one of the following purposes:

i. For the purposes of Research; or

ii. For the purposes of public health activities (not already allowed under HIPAA and the UAMS *Use and Disclosure of PHI Policy, 3.1.28*), such as disease registries maintained by UAMS, private organizations, other universities, or other types of studies undertaken by the private sector or nonprofit organizations for public health purposes; or

iii. For the purposes of UAMS Health Care Operations as defined in the UAMS *Use and Disclosure of PHI Policy, 3.1.28* and the HIPAA regulations.

c. **Data Use Agreement Required:** If the Limited Data Set information is to be disclosed outside UAMS, a Data Use Agreement must be entered with the recipient of the Limited Data Set information. Please contact the UAMS Research Privacy Officer when a Data Use Agreement is needed. All Data Use Agreements require the signature of the UAMS Research Privacy Officer and the authorized representative of the Limited Data Set recipient prior to disclosure.

d. **Minimum Necessary Applies:** The Limited Data Set information being used or disclosed must be the minimum necessary to accomplish the purpose of the Research. UAMS *Minimum Necessary Policy, 3.1.25*.

e. Refer to UAMS *De-Identification Policy, 3.1.31* to determine proper use/disclosure of Limited Data Set information, and also refer to the UAMS *Request for Data Extract Policy, 3.1.29*.

K. **USE of PHI in EXISTING DATABASES or CREATING A NEW DATABASE**

1. **Research on Existing Databases:** For use or disclosure of PHI for Research purposes from an existing database maintained by UAMS, UAMS must have one of the following:

   • Obtain the required HIPAA Research Authorizations in accordance with this Policy; or

   • Obtain an IRB Waiver of Authorization; or

   • Use or disclose PHI for Pre-Research purposes in accordance with this Policy; or

   • Use or disclose PHI for Research on decedents’ PHI in accordance with this Policy; or

   • Use or disclose only the Limited Data Set information and enter into a Data use Agreement...
with the recipient in accordance with this Policy; or

- Use or disclose PHI based on permission obtained prior to April 14, 2003 in accordance with the “Grandfathering” section of this Policy.

2. **Collecting PHI for Sole Purpose of Creating Research Database.** Prior to creating a database containing PHI for the purpose of Research, the PI must seek the patient/subject HIPAA Authorizations required under this policy, or seek a Waiver of Authorization from the IRB as described in this Policy.

L. **RECRUITMENT:** The IRB must approve all recruitment plans prior to the recruiting activity taking place, and the following are examples:

1. Physicians or their clinical staff may identify potential Research subjects from their own patients and contact the patients directly regarding their own IRB approved Research study.

2. Clinical staff, directly involved in patient care, can inform their patients of Research studies and give the patients contact information about Research studies for which they may qualify.

3. A researcher can provide IRB approved flyers and handouts to other physicians or care providers for an IRB approved Research study. These care providers can hand out the flyers and inform subjects to contact the researcher directly for information about the study.

4. IRB Approved Recruitment advertisements can be posted whereby potential subjects can initiate contact with the researcher.

5. Clinical care providers may send a letter or other type of mailing informing their patients of a Research study and provide contact information for the researcher. Initial contact should always be made by a care provider.

6. A researcher can ask care providers to inform their patients of a potential Research study. The researcher should provide the care provider with a Recruitment HIPAA Authorization form that the patient completes to give their permission for the Researcher to contact them regarding the study. The care providers ask their patients if they would like to be contacted to learn more about the study, the patient completes the form if interested and the care provider then forwards these forms to the researcher. The researcher may then contact the potential subject.

M. **TREATMENT RECORDS AND THE DESIGNATED RECORD SET:** A Designated Record Set means, for purposes of Research, medical records about individuals used, in whole or in part, by or for UAMS to make treatment decisions about individuals, including any treatment information generated in the research context. Documents containing the subject’s PHI in the course of Research and used in Research to make treatment decisions about the subject should be duplicated and the original record provided to the UAMS Health Information Management (HIM)/Medical Records Department for inclusion in the subject’s medical record.

N. **ACCOUNTING FOR DISCLOSURES**

1. **Accounting Required:** An accounting for disclosures is a method of documenting and tracking disclosures made by UAMS (both oral and written) of PHI to non-UAMS employees or other persons or entities outside UAMS. An example is an oral or written disclosure of PHI to comply with reporting requirements to the Arkansas Department of Health.

UAMS must account for “Disclosures” as defined herein, and in the HIPAA Privacy Regulations, for disclosures made...
without the individual’s Authorization, such as:

a. Disclosures of PHI made under an IRB waiver of authorization; and

b. Disclosures of PHI for Research on the deceased.

See “Exceptions” below.

2. **Accounting Form:** All such disclosures must be documented and accounted for by the PI who disclosed the PHI, or who is in charge of the project in which the PHI was disclosed, using the **Accounting For Disclosures Form attached to the UAMS Accounting of Disclosures Policy, 3.1.26,** or other method of documenting the disclosure, and including the information required in the UAMS **Accounting for Disclosures of PHI Policy, 3.1.26.** After completing the Form or documenting the disclosure, the Form or documentation must be provided to the UAMS Health Information Management Department (a/k/a UAMS Medical Records Department), Slot #524. Copies may be maintained by the PI.

3. **Multiple Disclosures to Same Person or Entity:** When multiple disclosures of PHI are made to the same person or entity for a single purpose, the accounting for such disclosures may consist of the information required for an accounting for the first disclosure, plus the number or frequency of disclosures, and the date of the last disclosure during the time period covered by the request.

4. **EXCEPTIONS - Accounting is Not Required:** UAMS is NOT required to account for disclosures of the PHI of individual subjects only if the following can be documented:

a. A valid HIPAA Research Authorization Form was signed by the individual who is the subject of the PHI being disclosed prior to the disclosure; or

b. Only De-Identified Information is being disclosed pursuant to the UAMS De-Identification Policy; or

c. Only Limited Data Set information is being disclosed and a Data Use Agreement was entered into with the recipient of the information, as described in this policy and the UAMS De-Identification Policy.
UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES

HIPAA RESEARCH AUTHORIZATION

STUDY TITLE:
Title

PRINCIPAL INVESTIGATOR:
Name
Address
Phone

CO-INVESTIGATORS:
Name
Address
Phone

STUDY SPONSOR:
Name

The word “you” means both the person who takes part in the research, and the person who gives permission to be in the research. This form and the research consent form need to be kept together.

We are asking you to take part in the research described in the consent form. To do this research, we need to collect health information that identifies you. We may collect the following information from your medical record: <list specific information that will be recorded>. This information will be used for the purpose of <list purpose of study>. We will only collect information that is needed for the research. Participating in this research study will create the following new health information: <list information that will be created>. For you to be included in this research, we need your permission to collect, create and share this information.

We will, or may, share your health information with people at the University of Arkansas for Medical Sciences (UAMS) who help with the research or things related to the research process, such as the study staff, the UAMS Institutional Review Board and the research compliance office at the University of Arkansas for Medical Sciences. We may share your information with the following researchers outside of the University of Arkansas for Medical Sciences: <list who>. We may also share your information with companies that pay for all or part of the research or who work with...
us on the research, such as the Sponsor listed above, or their legally authorized representative, or anyone who might purchase those companies at a later date. Additionally, we may need to share your health information with people outside of UAMS who make sure we do the research properly, such as the Office of Human Research Protections or the Food and Drug Administration. We believe that those involved with research understand the importance of preserving the confidentiality of your health information. However, some of the people outside of UAMS may share your health information with someone else. If they do, the same laws that UAMS must obey may not apply to others to protect your health information.

This authorization to collect, use and share your health information expires at the end of the research.

If you sign this form, you are giving us permission to create, collect, use and share your health information as described in this form. You do not have to sign this form. However, if you decide not to sign this form, you cannot be in the research study. You need to sign this form and the research consent form if you want to be in the research study. We cannot do the research if we cannot collect, use and share your health information.

If you sign this form but decide later that you no longer want us to collect or share your health information, you must send a letter to the person and the address listed by “Principal Investigator” on the first page of this form. The letter needs to be signed by you, should list the “Study Title” listed on this form, and should state that you have changed your mind and that you are revoking your “HIPAA Research Authorization”. You will need to leave the research study if we cannot collect and share any more health information. However, in order to maintain the reliability of the research, we may still use and share your information that was collected before the Principal Investigator received your letter withdrawing the permissions granted under this authorization.

During the course of the study, you may be denied access temporarily to certain medical information about you that is study related. However, the Principal Investigator and staff will not automatically deny a request, but will consider whether it is appropriate under the circumstances to allow access. If access is denied during the study, once the study is completed, you will be able to request access to the information again.

If you decide not to sign this form or change your mind later, this will not affect your current or future medical care at the University of Arkansas for Medical Sciences.

SIGNATURE, DATE, AND IDENTITY OF PERSON SIGNING

The health information about ______________ can be collected and used by the researchers and staff for the research study described in this form and the research consent form.

Signature:________________________________________

Date:_____________

Print name:_______________________________________

Relationship to participant:___________________________

The researcher will give you a signed copy of this form.

UAMS DATA USE AGREEMENT FOR THE LIMITED DATA SET

http://uams.edu/AdminGuide/Win03127.html

11/3/2005
This Data Use Agreement ("DUA") is made effective this ___ day of ______, 20__, ("Effective Date") by and between University of Arkansas For Medical Sciences ("Covered Entity") with offices at __________________________________________, and __________________________________________________ ("RECIPIENT"), with offices at __________________________________________________; individually, a “Party” and collectively, the “Parties”.

UAMS is a Covered Entity as defined in the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"); and

UAMS is providing RECIPIENT with a Limited Data Set of Protected Health Information ("PHI") as defined in HIPAA, thus rendering RECIPIENT a “Limited Data Set Recipient” as defined in HIPAA;

The Parties agree to the provisions of this DUA in order to address the requirements of HIPAA and to protect the interest of both Parties.

1. **DEFINITIONS:** Except as otherwise defined, any terms in this DUA shall have the definitions set forth in HIPAA. In the event of any inconsistency between the provisions of this DUA and mandatory provisions of HIPAA, as amended, the HIPAA definition shall control. Where provisions of this DUA are different than those mandated in HIPAA, but are nonetheless permitted by HIPAA, the provisions of this DUA shall control.

2. **USE OR DISCLOSURE:** RECIPIENT shall have the right to use all PHI provided to it by UAMS for the Research, Public Health or Health Care Operations purposes of:

[INSERT THE “USES OF THE DATA” TO BE PROVIDED BY UAMS TO RECIPIENT.]

and any other purpose in satisfaction of a judgment of a court of law or pursuant to any Federal or State law or regulation applicable to such PHI.

3. **RESTRICTIONS ON USE:** RECIPIENT agrees to not use or further disclose the PHI other than is permitted by this DUA, or as otherwise required by law. RECIPIENT shall use appropriate safeguards to protect the PHI from misuse or inappropriate disclosure and shall prevent any use or disclosure of the PHI other than as provided in this DUA. RECIPIENT shall not attempt to identify the individuals to whom the PHI pertains, or attempt to contact such individuals.

4. **REPORTING:** RECIPIENT shall report to UAMS any use or disclosure of the PHI not provided for in this DUA of which RECIPIENT is or becomes aware. RECIPIENT will take reasonable steps to limit any further such use or disclosure.

5. **TERMINATION:** This Agreement and all obligations hereunder, shall be effective on the Effective Date first set forth above and shall continue as long as RECIPIENT retains the data, unless otherwise terminated by applicable law or regulation. RECIPIENT may terminate this Agreement by returning or destroying the PHI. Should RECIPIENT commit a material breach of this Agreement, which breach is not cured within thirty (30) days after RECIPIENT receives notice of such breach from the Covered Entity, then the Covered Entity may discontinue disclosure of PHI and report the breach to the appropriate Privacy Officer at UAMS.

6. **RECIPIENT AS A COVERED ENTITY:** RECIPIENT acknowledges that if it is, itself, a covered entity as defined in HIPAA, then breach of this DUA will be treated as noncompliance with 45 CFR 164.514(e).

IN WITNESS WHEREOF, the Parties have executed this Data Use Agreement as of the day and year first set forth above.

Covered Entity (Covered Entity)

Limited Data Set Recipient
UAMS CERTIFICATION
FOR USE OR DISCLOSURE OF PROTECTED
HEALTH INFORMATION FOR THE PURPOSE OF REVIEW PREPARATORY TO RESEARCH (45 CFR 164.512(i)(1)(ii))

Name(s) and Address(es) of Investigator(s):

Name(s) and Address(es) of Covered Entity(ies) Where Protected Health Information is Located:

In accordance with 45 CFR 164.512(i)(1)(ii), the undersigned investigator(s) hereby certify(ies) that:

1. Said investigator(s) seek the use or disclosure of Protected Health Information (as defined in 45 CFR 164.501) located at the Covered Entity(ies), as defined in 45 CFR 160.102, named above solely to review such information as necessary to prepare a research protocol or for similar purposes preparatory to research;

2. Said investigator(s) shall not remove any Protected Health Information from the Covered Entity(ies) named above in the course of the review (and shall record only de-identified Protected Health Information); and

3. The Protected Health Information located at the Covered Entity(ies) named above is necessary for the research purposes of said investigator(s).

Signature(s) of Investigator(s):

________________________
Name
________________________
Signature
________________________
Date

UAMS CERTIFICATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION OF DECEASED INDIVIDUALS (45 CFR 164.512(i)(1)(iii))

Name(s) and Address(es) of Investigator(s):

Name(s) and Address(es) of Covered Entity(ies) Where Protected Health Information is Located:

In accordance with 45 CFR 164.512(i)(1)(iii), the undersigned investigator(s) hereby certify(ies) that:
1. Said investigator(s) seek the use or disclosure of Protected Health Information (as defined in 45 CFR 164.501) located at the Covered Entity(ies), as defined in 45 CFR 160.102, named above solely for research on the Protected Health Information of decedents;

2. Said investigator(s) shall, if requested, provide the Covered Entity(ies) named above with documentation of the death of the individuals for whose Protected Health Information said investigators seek use or disclosure; and

3. The Protected Health Information of decedents located at the Covered Entity(ies) named above is necessary for the research purposes of said investigator(s).

Signature(s) of Investigator(s):

_________________________
Name

_________________________
Signature

_________________________
Date
SCOPE

UAMS Workforce with Access to Confidential Information, including Electronic Protected Health Information (ePHI), for any purpose.

DEFINITIONS

Confidential Information includes information concerning UAMS research projects, confidential employee information, information concerning the UAMS research programs, proprietary information of UAMS, and sign-on and password codes for access to UAMS computer systems. Confidential information shall include Protected Health Information.

Electronic protected health information means individually identifiable health information that is:

- Transmitted by Electronic media
- Maintained in Electronic media

Protected Health Information (PHI) means information that is part of an individual’s health information that identifies the individual or there is a reasonable basis to believe the information could be used to identify the individual, including demographic information, and that (i) relates to the past, present or future physical or mental health or condition of the individual; (ii) relates to the provision of health care services to the individual; or (iii) relates to the past, present, or future payment for the provision of health care services to an individual. This includes PHI which is recorded or transmitted in any form or medium (verbally, or in writing, or electronically). PHI excludes health information maintained in educational records covered by the federal Family Educational Rights Privacy Act and health information about UAMS employees maintained by UAMS in its role as an employer.

UAMS Workforce means, for purposes of this Policy, physicians, employees, volunteers, trainees, and other persons whose conduct, in the performance of work for UAMS, are under the direct control of UAMS, whether or not they are paid by UAMS.

To access any other terms or definitions referenced in this policy:
http://hipaa.uams.edu/DEFINITIONS%20-%20HIPAA.pdf
POLICY

UAMS IT Security will implement procedures to ensure that UAMS Workforce members are granted appropriate access to ePHI. ePHI access will be terminated when the UAMS workforce member’s employment ends or when a determination is made that such access should be terminated or otherwise modified. (UAMS Confidentiality Policy 3.1.15) UAMS IT Security processes the termination of all employees in accordance with the UAMS Employee Separation Procedure 4.5.16.

PROCEDURE:

These procedures help ensure the timely disabling of UAMS network and information system account(s) and the removal of physical access to UAMS facilities.

A. Departments are responsible for updating employee status (job change or termination) in the UAMS Financial System (SAP) on a timely basis.

B. The UAMS Financial System (SAP) will send a list of all UAMS workforce terminations (voluntarily or involuntarily) to IT Security. When the employment of a UAMS workforce member ends, their information systems privileges, both internal and remote, will be disabled. If the employee is dismissed involuntarily, it is the supervisor’s responsibility to ensure compliance with these actions.

C. Department supervisors are responsible for reviewing transferring employees’ computer access levels and notifying the Department’s IT Administrator or the UAMS IT Security Office (either by e-mail, phone call (501-526-6028) or by completing the IT System Access Form) of any computer system access levels that must be maintained, assigned or deactivated.

D. Physical access to UAMS facilities after termination or transfer. Please refer to UAMS Administrative Guide 11.1.4 Key Requests/Transfers for additional details.

1. Terminations: Upon separation from UAMS, physical access to UAMS facilities is also terminated. As a part of the clearance procedure, faculty and staff shall return all keys to the Physical Plant Key Officer.

2. Transferring work force members: Direct key transfers to other employees are not permitted. All keys must be returned to the Physical Plant Key Office by the person to whom they were issued.

3. The Department of the terminating or separating employee will notify the Physical Plant Key Office if a determination is made that locks need to be re-keyed or combinations changed.
UAMS ADMINISTRATIVE GUIDE

NUMBER: 3.1.25
DATE: 04/01/03
REVISION: 03/01/04

SCOPE

UAMS Workforce

DEFINITION

Disclosure means the release, transfer, provision of access to, or divulging of information in any manner (verbally or in writing) by UAMS to persons who are not UAMS employees or students, or to any other person or entity OUTSIDE of UAMS.

Minimum Necessary means limiting Protected Health Information to the minimum necessary to accomplish the intended purpose of the use, disclosure or request.

Protected Health Information (PHI) means information that is part of an individual’s health information that identifies the individual or there is a reasonable basis to believe the information could be used to identify the individual, including demographic information, and that (i) relates to the past, present or future physical or mental health or condition of the individual; (ii) relates to the provision of health care services to the individual; or (iii) relates to the past, present, or future payment for the provision of health care services to an individual. This includes PHI which is recorded or transmitted in any form or medium (verbally, or in writing, or electronically). PHI excludes health information maintained in educational records covered by the federal Family Educational Rights Privacy Act and health information about UAMS employees maintained by UAMS in its role as an employer.

Required by law generally means a requirement in the law that compels an entity to make a use or disclosure of information that is enforceable in a court of law. For example, some state and federal statutes or regulations require hospitals to report certain health information to the Arkansas Department of Health, the Arkansas Department of Human Services, the Arkansas State Medical Board, the Arkansas State Board of Nursing, or the Arkansas Pharmacy Board.

UAMS Workforce means for purposes of this Policy, physicians, employees, volunteers, trainees, and other persons whose conduct, in the performance of work for UAMS, are under the direct control of UAMS, whether or not they are paid by UAMS.

Use means the sharing, employment, application, utilization, examination, or analysis within UAMS.

POLICY

For Protected Health Information (PHI) that is subject to the minimum necessary requirements of the

http://uams.edu/AdminGuide/Win03125.html

11/3/2005
HIPAA regulations, UAMS will make reasonable efforts to limit the use or disclosure of, and requests for, PHI to the minimum necessary to accomplish the intended purpose of the use, disclosure or request. This policy is not intended in any way to impede access to information necessary to make medical decisions and provide treatment to patients. UAMS health care professionals must have timely and sufficient access to patient information for treatment purposes and will use their professional judgment to determine the minimum necessary patient information required to provide such treatment.

**PROCEDURE**

A. **Exclusions:** The minimum necessary requirement does not apply to any of the following:
   1. Disclosures to or requests by a health care provider (outside UAMS) for treatment purposes;
   2. Uses or disclosures made to the individual who is the subject of the information;
   3. Uses or disclosures made pursuant to a valid and HIPAA-compliant authorization signed by the patient or patient’s Legal Representative;
   4. Disclosures made to the United States Department of Health and Human Services, or any officer or employee of that Department to whom the authority involved has been delegated;
   5. Uses or disclosures Required by Law; and
   6. Uses or disclosures required for compliance with other applicable laws and regulations.

B. UAMS will identify the classes of persons or job titles within the UAMS workforce who need access to PHI to carry out their job responsibilities. UAMS will identify the category or categories of PHI to which these individuals need access, and the conditions appropriate to such access.

C. For **Uses** of PHI by UAMS health care professionals for **treatment:** UAMS physicians, nurses or other health care professionals may have access to and use the entire medical record of a patient, as needed, for purposes of treatment of that patient. The UAMS physicians, nurses and other health care professionals will use their professional judgment to determine the minimum necessary PHI needed for purposes of treatment, and will not be precluded from having access to the entire medical record or any other Protected Health Information determined by the health care professional to be needed for this purpose.

D. **All other uses or disclosures** subject to the minimum necessary requirements will be reviewed by persons having an understanding of the UAMS privacy policies and practices, and sufficient expertise to understand and weigh the necessary minimum necessary factors.
   1. Except for the uses or disclosures of PHI specifically excluded from the “minimum necessary” rule identified under “exclusions” in this policy, UAMS will only use, disclose, or request an entire medical record when the entire medical record is specifically justified as being reasonably necessary to accomplish the purpose of the use, disclosure, or request.
   2. Authorized levels of access shall be determined by job classifications or functions. In unusual or emergency situations, the classes of persons or job titles of UAMS employees may be re-evaluated to determine if additional access to PHI is needed to carry out job
3. Although UAMS is not required to rely on the following requests to be the minimum necessary, UAMS workforce may reasonably rely on requests made by:
   a. public health and law enforcement agencies to determine the minimum necessary information for certain disclosures; or
   b. other covered entities to determine the minimum necessary information for certain disclosures; or
   c. a professional who is a member of the UAMS workforce, or is a business associate of UAMS for the purpose of providing professional services to UAMS, if the professional or business associate represents that the information requested is the minimum necessary for the stated purpose; or
   d. a researcher with appropriate documentation from an Institutional Review Board (IRB) or Privacy Board.

4. For determination of the minimum amount of PHI necessary for disclosures in connection with research purposes, refer to UAMS HIPAA Research Policy, #3.1.27.

F. **Need-To-Know:** Employees will only access PHI on a need-to-know basis for carrying out their specific job duties.
UAMS ADMINISTRATIVE GUIDE

NUMBER: 3.1.22
DATE: 10/01/04
REVISION: 3/24/2005

SECTION: INFORMATION TECHNOLOGY
AREA: NETWORK SECURITY
SUBJECT: MITIGATION OF USES/DISCLOSURES IN VIOLATION OF HIPAA

SCOPE

UAMS Workforce with Access to Confidential Information, including Electronic Protected Health Information (ePHI), for any purpose.

DEFINITIONS

Confidential Information includes information concerning UAMS research projects, confidential employee information, information concerning the UAMS research programs, proprietary information of UAMS, and sign-on and password codes for access to UAMS computer systems. Confidential information shall include Protected Health Information.

Electronic protected health information means individually identifiable health information that is:

- Transmitted by Electronic media
- Maintained in Electronic media

Mitigate means the steps taken to lessen the harm or potential harm resulting from an improper use or disclosure of Protected Health Information, including electronic Protected Health Information.

Protected Health Information (PHI) means information that is part of an individual’s health information that identifies the individual or there is a reasonable basis to believe the information could be used to identify the individual, including demographic information, and that (i) relates to the past, present or future physical or mental health or condition of the individual; (ii) relates to the provision of health care services to the individual; or (iii) relates to the past, present, or future payment for the provision of health care services to an individual. This includes PHI which is recorded or transmitted in any form or medium (verbally, or in writing, or electronically). PHI excludes health information maintained in educational records covered by the federal Family Educational Rights Privacy Act and health information about UAMS employees maintained by UAMS in its role as an employer.

UAMS Workforce means, for purposes of this Policy, physicians, employees, volunteers, trainees, and other persons whose conduct, in the performance of work for UAMS, are under the direct control of UAMS, whether or not they are paid by UAMS.

To access any other terms or definitions referenced in this policy: http://hipaa.uams.edu/DEFINITIONS%20-%20HIPAA.pdf

POLICY

UAMS will, to the extent practicable, mitigate any harmful effects that are known to UAMS of a use or disclosure of Protected Health Information, including electronic Protected Health Information by UAMS, its Business Associate or Contractors in violation of the HIPAA regulations or the UAMS policies and procedures relative to the requirements of the HIPAA regulations.

PROCEDURE

A. When UAMS supervisors, managers or department directors are informed that Protected Health Information (PHI) or electronic Protected Health Information (ePHI) has been improperly used or disclosed, such facts will be communicated to the appropriate UAMS Privacy or Security Officer. The Officer notified will contact the UAMS HIPAA Officer to coordinate the investigation and undertake mitigation efforts. The mitigation process must occur in accordance with the UAMS HIPAA Compliance Plan.

B. If UAMS determines that PHI or ePHI has been improperly used or disclosed by a member of the UAMS workforce, appropriate disciplinary action will be initiated and documented.

C. If UAMS determines that PHI or ePHI has been improperly used or disclosed by a Business Associate or Contractor, UAMS will:
1. Investigate the incident;
2. Counsel the Business Associate or Contractor on the incident;
3. Monitor the Business Associate’s or Contractor’s performance for a reasonable period of time following the incident; and
4. If UAMS determines that the Business Associate or Contractor has not taken appropriate steps to remedy the situation leading to the inappropriate use or disclosure, UAMS will terminate the Business Associate or Contractor relationship. Refer to UAMS Business Associate Policy, 3.1.33.
UAMS ADMINISTRATIVE GUIDE

NUMBER: 3.1.17
DATE: 10/16/02
REVISION: 10/05/05

SECTION: GENERAL ADMINISTRATION
AREA: ADMINISTRATION
SUBJECT: MOBILE DEVICE SAFEGUARDS

SCOPE

UAMS Physicians, Faculty, Employees and Students

DEFINITIONS

Mobile Devices are defined as Personal Digital Assistants (PDAs), tablets, cellular phones, text pagers, laptop computers, and any other types of mobile devices or media that receive, record or store information and data.

Protected Health Information (PHI) means information that is part of an individual’s health information that identifies the individual or there is a reasonable basis to believe the information could be used to identify the individual, including demographic information, and that (i) relates to the past, present or future physical or mental health or condition of the individual; (ii) relates to the provision of health care services to the individual; or (iii) relates to the past, present, or future payment for the provision of health care services to an individual. This includes PHI which is recorded or transmitted in any form or medium (verbally, or in writing, or electronically). PHI excludes health information maintained in educational records covered by the federal Family Educational Rights Privacy Act and health information about UAMS employees maintained by UAMS in its role as an employer.

To access any other terms or definitions referenced in this policy: UAMS HIPAA

POLICY

All UAMS physicians, faculty, employees, and students who use Mobile Devices to access or record Protected Health Information (PHI) are responsible for the protection of the data. Mobile Device users must take the necessary steps to safeguard that information from unauthorized or improper disclosure in violation of UAMS Policies and Procedures or the HIPAA Regulations.

PROCEDURE

A. **Password Protections:** All persons who use Mobile Devices to access or store PHI are required to use the device’s password protection feature and use the automatic time out or password protected screen saver feature if available. PHI must be safeguarded in the event the Mobile Device is lost, stolen, or otherwise accessible by someone other than the user of the device who is authorized to have access to the PHI.

B. **Repairs:** Before sending a Mobile Device for outside repair, the user must make certain that all PHI has been deleted and erased from storage so that any PHI previously stored in the device is rendered completely inaccessible to service technicians or other persons. In the event access to the PHI is necessary for the repairs to be made, a Business Associate Agreement must be in place with the vendor making the repairs. UAMS Business Associate Agreement

http://www.uams.edu/adminguide/Win03117.html
C. **Beaming:** If PHI is beamed via an infrared information stream, it is possible for another device to inadvertently pick up the transmission. Beaming should take place in the presence of only two (2) Mobile Devices and should be held less than 4 inches apart for the duration of the transmission.

D. **Wireless Transmissions:** Security measures required by UAMS must be taken when sending PHI in electronic form. Questions regarding specific security measures required should be directed to the UAMS IT Help Desk at (501) 686-8555. Care must be taken to enter the correct pager/cellular phone number when transmitting PHI in text format.

E. **Storage:** When not in use, Mobile Devices containing PHI must be stored in a secure manner to prevent access by persons who are not authorized to view the PHI stored in the device.

F. **Reporting:** If a Mobile Device containing PHI is lost or stolen, it must be reported immediately to the UAMS IT Security Officer by calling (501) 686-8555 and the UAMS Campus Police by calling 686-7777.

G. **Data Removal:** The Mobile Device user is responsible for deleting PHI in a timely manner when storage in the device is no longer necessary. Upon termination of the user’s employment or other relationship with UAMS, users must remove all PHI from the Mobile Device and any other non-UAMS electronic devices so that the PHI previously stored on the device is rendered inaccessible. Questions regarding data removal should be directed to the UAMS IT Help Desk by calling (501) 686-8555.
DEFINITIONS

**Indirect Treatment Relationship:** A relationship between a patient and healthcare provider in which:

1. The healthcare provider delivers healthcare directly to the patient based on the orders of another healthcare provider; and

2. The healthcare provider typically provides services or product, or reports the diagnosis or results associated with the healthcare, directly to another healthcare provider, who provides the services or product or reports to the patient.

**Protected Health Information (PHI)** means information that is part of an individual’s health information that identifies the individual or there is a reasonable basis to believe the information could be used to identify the individual, including demographic information, and that (i) relates to the past, present or future physical or mental health or condition of the individual; (ii) relates to the provision of health care services to the individual; or (iii) relates to the past, present, or future payment for the provision of health care services to an individual. This includes PHI which is recorded or transmitted in any form or medium (verbally, or in writing, or electronically). PHI excludes health information maintained in educational records covered by the federal Family Educational Rights Privacy Act and health information about UAMS employees maintained by UAMS in its role as an employer.

**UAMS Workforce** means for purposes of this Policy, physicians, employees, volunteers, trainees, and other persons whose conduct, in the performance of work for UAMS, are under the direct control of UAMS, whether or not they are paid by UAMS.

POLICY

UAMS patients will be provided the UAMS *Notice of Privacy Practices (Notice)* that describes how UAMS uses and discloses protected health information. It will also include the individual's rights and UAMS' legal duties with respect to protected health information. All UAMS HIPAA covered components shall use the UAMS *Notice of Privacy Practices*. Any modifications to the Notice must be approved by the UAMS HIPAA Oversight
PROCEDURE

A. **Content of the Notice** - The UAMS *Notice of Privacy Practices* conforms to §164.520 of the Health Insurance Portability and Accountability Act.

B. **Distribution and publication of the Notice** - Each UAMS HIPAA covered component will be responsible for making the UAMS *Notice of Privacy Practices* available to its patients in accordance with the HIPAA regulations.

1. For patients with whom UAMS has a **direct treatment relationship**, UAMS will:
   
   a. Provide the *Notice* to the patient no later than the date of the first service delivery after April 14, 2003. Make a good faith effort to obtain the individual's written *Acknowledgment* that they received the *Notice*. Document the reason if the written Acknowledgment was not obtained.
   
   b. Post the *Notice* in a clear and prominent location; and
   
   c. Make the *Notice* available at all service delivery sites.

2. The *Notice* will be provided to patients who have an **indirect treatment relationship** and are physically present at UAMS. The *Notice* will be available upon request to patients not physically present and who have an **indirect treatment relationship** at UAMS. An example of this is: mail-in specimens to the UAMS Clinical Laboratory.

3. In emergency situations, the provision of the *Notice* and its written Acknowledgment may be given as soon as reasonably practicable after the emergency treatment situation.

4. The *Notice* will be prominently posted on all UAMS public websites.

5. The *Notice* will be made available in English and Spanish. Other interpretive accommodations will be provided upon request. Refer to University Hospital *Interpreters Policy P.S.2.07*.

6. An audio version, in Spanish and English, of the *Notice of Privacy Practices* and Acknowledgment may be accessed by dialing (501) 526-7270 or 866-273-3554 (toll free number).

D. **Documentation Requirements**: A copy of the *Notice* and each subsequent revision will be retained for six years by the UAMS HIPAA Office.

*Acknowledgment of Receipt of Privacy Notice*

By signing this form, you are only agreeing that you have received a copy of the UAMS Notice of Privacy Practices.
STAFF USE ONLY

We provided the Notice of Privacy Practices and attempted to obtain written Acknowledgment but acknowledgment could not be obtained because:

☐ Patient or Legal Representative declined to sign the Acknowledgment of Receipt.
Other (please specify)________________________________________

Printed Name of Employee Completing Form Date ____________________________
Signature of Employee Completing Form UAMS Location

EPF Barcode HIPAA
SCOPE:

UAMS Physicians, Staff, Faculty, Students and Volunteers

POLICY:

All UAMS patients have the right to request restrictions on the use and disclosure of their Protected Health Information. UAMS is not required to agree to any restriction request. UAMS will not agree to any request to restrict information which UAMS is required by law to use or disclose.

PROCEDURE:

A. **Right to Request Restrictions:** Patients will be advised by UAMS Notice of Privacy Practices that they have a right to request restrictions on the use and disclosure of their Protected Health Information. Specifically, patients have the right to request that UAMS restrict:

1. Uses or disclosures of PHI about the patient to carry out treatment, payment or health care operations of UAMS; or
2. Disclosures made to family and friends involved in the patient’s care.

B. **Requirements for Requesting Restrictions:** The patient’s request for restrictions must be in writing and must include the following:

1. A description of the information that is to be restricted;
2. A statement whether the restriction applies to use, disclosure or both; and
3. To whom the restrictions will apply.

The form attached to this Policy must be completed and signed by the patient in order to process the request. The patient’s request must be approved by a UAMS authorized individual. The patient should be informed that the request, if agreed upon, will apply only to the UAMS clinic or facility with which the patient has submitted the request. If the patient wishes for restrictions to apply to other clinics or facilities of UAMS involved in the patient’s care, the patient should be informed that he/she must submit the request form to the individual UAMS clinics or facilities. Although UAMS is not required to inform the patient, UAMS may inform the patient verbally or in writing of a denial of a request submitted in writing and in accordance with this Policy. If the patient is informed verbally of a denial of a restriction request, this should be documented on the form. The completed Form should be maintained in the patient’s medical record and a copy sent to the UAMS HIPAA Office, #829.

C. **Emergency Situations:** If UAMS has agreed to a restriction, UAMS may not use or disclose PHI in violation...
of the restriction, except that, if the patient is in need of emergency treatment and the restricted PHI is needed to provide
the emergency treatment, UAMS may use the restricted PHI, or may disclose such information to a health care
provider, to provide the treatment to the patient.

D. **Ineffective Restrictions:** A restriction agreed to by UAMS is not effective to prevent disclosures to:

1. Secretary of the United States Department of Health and Human Services to investigate or determine
   UAMS’ compliance with the HIPAA regulations; or

2. Uses or disclosures required by law for:
   a. public health activities;
   b. health oversight activities;
   c. to report abuse, neglect or domestic violence;
   d. judicial and administrative proceedings;
   e. compliance with workers compensation proceedings in which patient has filed a workers
      compensation claim;
   f. aw enforcement purposes;
   g. to report a crime in an emergency;
   h. coroners and medical examiners;
   i. organ, eye or tissue donation purposes;
   j. circumstances in which UAMS believes in good faith is necessary to prevent or lessen a
      serious and imminent threat to the health or safety of a person or to the public; or
   k. correctional institutions or other law enforcement custodial situations.

3. Insurance companies or other third party payors for purposes of payment of health care services provided
to the patient.

See UAMS *Uses and Disclosure of PHI and Medical Record Policy, 3.1.28* for more information.

E. **Termination of Agreed Restrictions:** UAMS may terminate its agreement to a restriction if:

1. the patient agrees to or requests the termination in writing;

2. the patient orally agrees to the termination and the oral agreement is documented; or

3. UAMS informs the patient that it is terminating its agreement to a restriction, except that such
   termination is only effective with respect to PHI created or received after UAMS has informed the
   patient.

UAMS is not required to abide by the “Termination of Agreed Restrictions” requirements when the restrictions do not
apply in emergencies as described in Section E of this Policy, or when the restrictions are ineffective under the HIPAA
regulations as described in Section D of this Policy.
For a printable version of the form below, please see the Patient Request to Restrict Use/Disclosure of Health Information Word document.

Patient label if available or

_____________________

Print patient name

_____________________

and account number

**Patient Request to Restrict Use/Disclosure of Health Information**

(to be completed with assistance of clinic/facility manager or other designee)

/FACILITY NAME: ___________________________________________________________

request the following restriction on the use or disclosure of my health information:

Describe the information you want restricted:

Check whether you want the information restricted from use by UAMS or disclosure outside of UAMS, or both by checking one of the boxes that apply to your request:

] Do not use this information within UAMS

] Do not disclose this information outside UAMS

Specify the persons or entities you want this restriction applied to:

EQUEST WILL APPLY ONLY TO THIS CLINIC/FACILITY.

] WISH FOR RESTRICTIONS TO APPLY TO ANY OTHER UAMS CLINIC OR FACILITY, PLEASE CONTACT THE FACILITY AND COMPLETE A RESTRICTION REQUEST FORM.

EQUEST IS SUBJECT TO REVIEW AND MAY NOT BE APPROVED.

of Patient or Legal Representative Date

Representative, authority of Legal Representative (parent of a minor, court-appointed guardian, administrator of estate of deceased, attorney-in-fact appointed with power of attorney re proxy)

http://uams.edu/AdminGuide/Win03134.html

11/3/2005
3.1.34 PATIENT INFORMATION RESTRICTION REQUESTS

Response to request: [ ] agreed to request [ ] denied request

Patient: [ ] verbally [ ] in writing Date: ______________________

____________________________

Signed in Patient’s medical record and send a copy to the UAMS HIPAA Office, #829

____________________________

e of UAMS Authorized Personnel Date

UAMS ADMINISTRATIVE GUIDE

NUMBER: 3.1.32  
DATE: 04/01/03  
REVISION: 03/01/04

SCOPE

UAMS Workforce

DEFINITIONS

Designated Record Set means a group of records maintained by or for UAMS in which the records are either:

- the medical and billing records about patients maintained by or for UAMS; or
- records used, in whole or in part, by or for UAMS to make decisions about patients.

For purposes of the term “record” in the definition of Designated Record Set, this includes any item, collection or grouping of information that includes Protected Health Information and is maintained, collected, used or disseminated by or for UAMS.

Protected Health Information (PHI) means information that is part of an individual’s health information that identifies the individual or there is a reasonable basis to believe the information could be used to identify the individual, including demographic information, and that (i) relates to the past, present or future physical or mental health or condition of the individual; (ii) relates to the provision of health care services to the individual; or (iii) relates to the past, present, or future payment for the provision of health care services to an individual. This includes PHI which is recorded or transmitted in any form or medium (verbally, or in writing, or electronically). PHI excludes health information maintained in educational records covered by the federal Family Educational Rights Privacy Act and health information about UAMS employees maintained by UAMS in its role as an employer.

UAMS Workforce means for purposes of this Policy, physicians, employees, volunteers, trainees, and other persons whose conduct, in the performance of work for UAMS, are under the direct control of UAMS, whether or not they are paid by UAMS.

POLICY

UAMS patients have the right to request that UAMS amend their Protected Health Information or other records about the patient maintained in a Designated Record Set for as long as the Protected Health Information is maintained in a Designated Record Set.

PROCEDURE

A. Amendment Requests: Requests by the patient to amend or correct information maintained in the patient’s medical record or other records maintained in the UAMS Designated Record Set must be made in writing and...
include a reason to support such a request. Routine requests for amendments or corrections to the patient’s contact information or other non-medical information are not required to be in writing, and may be handled according to the appropriate department policy and procedure.

**B. Response Time:** UAMS must act on a patient’s request for an amendment within sixty (60) days after receipt of the request in writing. If UAMS is unable to act on the request within the 60-day period, UAMS may have a one-time extension of not more than thirty (30) additional days, as long as UAMS has informed the individual in writing of the delay, the reasons for the delay, and a date that UAMS will provide a response.

**C. Basis for Denial of Request:** UAMS may deny the amendment request under any one of the following circumstances:

- UAMS did not create the record. If UAMS determines that the patient has provided a reasonable basis to believe that the originator of the record is no longer available to act on the request, UAMS must consider the request, but the request may be denied for other reasons stated in this Policy.

- The information which the patient requests to be amended is not part of a UAMS Designated Record Set.

- The information which the patient requests to be amended is not otherwise available for inspection by the patient under the HIPAA regulations governing a patient’s right to access his/her PHI, 45 C.F.R. § 164.524, such as psychotherapy notes, records that are prohibited by law from being released to the individual, and release of the information may endanger the safety of the individual or another person. See UAMS Use and Disclosure of PHI, and Medical Record Policy regarding when UAMS may deny a patient or a patient’s legal representative access to the patient information.

- UAMS determines that the information is accurate and complete.

**D. Denial Must Be In Writing:** If a request to amend is denied, in whole or in part, UAMS must provide the patient with a written denial within the time allowed, using plain language, and must include the following information:

- the basis for the denial; and

- the patient's right to submit a written statement disagreeing with the denial and how to file such a statement; and

- a statement that, if the patient does not submit a statement of disagreement, they may request that UAMS provide their request for amendment and the denial with any future disclosure of the PHI that is the subject of the amendment; and a description of how the patient may complain to UAMS pursuant to the UAMS complaint procedures by contacting the UAMS HIPAA Office at 4301 West Markham Street, #829, Little Rock, AR 72205, or by calling the HIPAA Office at (501-614-2187), or to submit a complaint to the Secretary of the United States Department of Health and Human Services.

**E. Patient’s Disagreement With Denial of Request:**

1. **Statement of Disagreement:** If UAMS denies all or part of the amendment request, the patient may submit a written statement of disagreement and the basis for such a disagreement. UAMS may reasonably limit the length of a statement of disagreement.

2. **Rebuttal Statement:** UAMS may prepare a written rebuttal to the patient's statement of disagreement. When a rebuttal is prepared, UAMS must provide a copy to the patient who submitted the statement of disagreement.

3. **Record Keeping:** UAMS will identify the record or PHI in the designated record set that is the subject of the disputed amendment and append or otherwise link the patient's request for an amendment, UAMS' denial of the request, the patient's statement of disagreement, if any, and UAMS’ rebuttal, if any, to the
4. **Future Disclosures:**

- If a statement of disagreement has been submitted, UAMS will include the material appended in accordance with the record keeping section above, or an accurate summary, with any subsequent disclosure of the PHI that the disagreement relates to.

- If a written statement of disagreement has not been submitted, UAMS must include the patient's request for amendment and its denial, or an accurate summary of such information, with any subsequent disclosure of the PHI only if the individual has requested such action.

- When a subsequent disclosure described above is made using a standard transaction that does not permit the additional material to be included with the disclosure, UAMS may separately transmit the material required by this section to the recipient of the standard transaction.

**F. Recordkeeping of Amendment Requests/Denials:** Except for routine requests to amend demographic and contact information concerning the patient, all patient amendment requests should be submitted to the HIM/Medical Records Department using the UAMS Amendment Request Form. If the patient communicates with the provider directly about an amendment request, the provider may elect to respond verbally to the request at that time; however, if the provider elects to respond to the patient’s request at that time, and the request is not a routine request to amend demographic and contact information concerning the patient, the Amendment Request form must be filled out during the patient’s visit, and the form must include the provider's response, and the completed form must be forwarded to the HIM/Medical Records department.

All documentation regarding requests to amend, and documentation regarding UAMS’ response to the request, must be submitted to the Medical Records Department to retain for a period of at least six (6) years from the date of the documentation.

**G. Agreeing to Amendment Request:** If UAMS agrees, in whole or in part, to the patient’s requested amendment, UAMS will:

1. **Make the appropriate amendment** to the information that is the subject of the request by identifying the records in the Designated Record Set that are affected by the amendment and appending or otherwise providing a link to the location of the amendment. With the exception of demographic information, medical information should never be deleted. Instead, the “amendment” must be made in the form of an addition to the record and as required by Arkansas law. Demographic changes may be made without having to maintain a historical file of the change.

2. **Inform the individual** that the amendment is accepted and obtain their identification of and agreement to have UAMS notify the relevant persons with which the amendment needs to be shared. The acceptance of the amendment is not required to be in writing to the patient.

3. **Inform others:** UAMS will make reasonable efforts to inform and provide the amendment within a reasonable time to:
   - persons identified by the patient as having received PHI about them and needing the amendment; and
   - persons, including business associates of UAMS, that UAMS knows to have the PHI that is the subject of the amendment and who may have relied or could foreseeable rely upon such information to the detriment of the individual.

**H. When Amendments Made by Others Outside UAMS:** If UAMS is informed by another covered entity of its amendment to a patient's PHI maintained by the covered entity, and UAMS has PHI or other records in its Designated Record Set affected by such amendment, UAMS will amend the PHI in its Designated Record Set accordingly.

http://uams.edu/AdminGuide/Win03132.html

11/3/2005
Patient label if available

Request for Amendment of Health Information

Patient Name: ___________________________ Birth Date: __________________________

Patient Account Number: __________________ Phone: __________________________

Patient Address: __________________________________________________________________

Date of entry to amend: ____________ Type of entry to amend: __________________________

Explain how entry is incorrect or incomplete. What should the entry say to be more accurate or complete?

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Identify persons who have received health information about you whom you agree need notice of this amendment, if amendment accepted. Please specify the name and address:

____________________________________________________________________________________

(UAMS will identify others whom it knows have health information that need amendment and document such notice.)

Signature of Patient or Legal Representative

Print Name of Legal Representative

Date __________________________

If Legal Representative, authority of Legal Representative ____________________________

(such as parent of a minor, court-appointed guardian, administrator of estate of deceased, attorney-in-fact appointed with power of attorney, or healthcare proxy)
Staff Use Only

Date request received: ___________________ Amendment: _____ Accepted _____ Denied

Patient Notified on: ________________ (must be within 60 days of request). If denied, notify in writing.

Patient Notified by ______________________________________________________________ (name).

If denied, check reason for denial: _____ PHI was not created by this organization

_____ PHI is accurate and complete _____ Other reason (describe): ________________________________

____________________________________________________________________________________

Comments, if any: _____________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

Signature of UAMS Authorized Personnel Date

____________________________ ______________________________________

Printed Name

- Request for Amendment of Health Information Form (Word format)
UAMS ADMINISTRATIVE GUIDE

NUMBER: 3.1.35
DATE: 04/01/03
REVISION: 3/1/2004

SECTION: GENERAL ADMINISTRATION
AREA: ADMINISTRATION
SUBJECT: POLICY ON USE OF PHI FOR FUNDRAISING

SCOPE

UAMS physicians, employees, volunteers, trainees, and other persons whose conduct, in the performance of work for UAMS, is under the direct control of UAMS, whether or not they are paid by UAMS.

PURPOSE

To establish guidelines and restrictions for the use and disclosure of Protected Health Information in connection with all UAMS fundraising activities.

DEFINITIONS

For purposes of this policy, the following definitions apply:

Demographic Information shall be limited to the following types of information: (a) the patient’s name, address, and other contact information; (b) age; (c) gender; and (d) insurance status.

Fundraising means any activity relating to the efforts of raising funds for the institution of UAMS and its related healthcare facilities.

Protected Health Information (PHI) means information that is part of an individual’s health information that identifies the individual or there is a reasonable basis to believe the information could be used to identify the individual, including demographic information, and that (i) relates to the past, present or future physical or mental health or condition of the individual; (ii) relates to the provision of health care services to the individual; or (iii) relates to the past, present, or future payment for the provision of health care services to an individual. This includes PHI which is recorded or transmitted in any form or medium (verbally, or in writing, or electronically). PHI excludes health information maintained in educational records covered by the federal Family Educational Rights Privacy Act and health information about UAMS employees maintained by UAMS in its role as an employer.

POLICY

UAMS may not use or disclose a patient’s Protected Health Information (PHI) for Fundraising purposes except as allowed by federal and state law, including the Federal HIPAA Privacy Regulations. UAMS will include an opt-out provision in its Fundraising materials to instruct the recipient on how to opt out of receiving future communications relating to Fundraising.

PROCEDURES

A. Information Which Can Be Used/Disclosed for Fundraising: UAMS may use, or disclose to a business associate or to an institutionally related foundation, the following information about the patient for the purpose of raising funds for the benefit of UAMS, without the patient’s prior authorization or consent:
- Name
- Address
- Other contact information
- Age
- Gender
- Insurance status
- Dates of healthcare services provided to patient

UAMS may also use the following information for Fundraising purposes:
- public information
- information obtained outside UAMS
- information provided voluntarily by the patient to a member of UAMS’ fundraising staff and the patient is aware that it is a member of the UAMS fundraising staff.

B. **Authorization Required for Use/Disclosure of PHI for Fundraising:** Except for the information listed above, no other PHI may be used or disclosed by UAMS for Fundraising purposes, without the patient’s signed authorization. The authorization must be an approved UAMS Authorization form allowing the use or disclosure of PHI for fundraising purposes.

Information about the department in which the patient received services also cannot be used or disclosed for Fundraising purposes without the patient’s prior authorization, if that information would reveal or could reveal the patient’s treatment, diagnosis, or nature of healthcare services. For example, UAMS may not use or disclose for Fundraising purposes the fact that the patient received services from the Department of Psychiatry, the Department of Obstetrics, or the Department of Radiation Oncology.

Examples of PHI which cannot be used or disclosed for Fundraising purposes:

- Diagnosis
- Nature of services
- Treatment
- Place within UAMS where patient received services that specifically identifies the patient’s diagnosis, nature of services or treatment received, such as:
  - Department of Psychiatry
  - Department of Obstetrics
  - Department of Radiation Oncology

While UAMS may undertake any Fundraising activities targeted for a specific department or type of illness, UAMS may not use or disclose a patient’s PHI to do so (other than as described above in “Information Which Can Be Used/Disclosed for Fundraising”).

C. **Opt-Out Provision in Fundraising Materials:** UAMS will include in all Fundraising materials instructions on how the individual may opt out of receiving any future communications relating to Fundraising. An example of
such language would be: “Please write to us at our address if you wish to opt out of future development mailings,” and the address information would be included. UAMS must make reasonable efforts to ensure that individuals who decide to opt out of receiving Fundraising communications are not sent such communications.

D. **Business Associate Agreement:** UAMS will enter into an appropriate Business Associate Agreement pursuant to the UAMS *Business Associate Policy, 3.1.33* prior to disclosing any PHI (including the Demographic Information and dates of healthcare services described above) to an outside consultant or outside entity for Fundraising activities on behalf of UAMS. An institutionally related foundation to whom UAMS discloses PHI for fundraising activities on behalf of UAMS is not considered a “Business Associate” for purposes of this Policy.
UAMS ADMINISTRATIVE GUIDE

NUMBER: 3.1.24
DATE: 04/01/03
REVISION: 03/01/04

SECTION: ADMINISTRATION
AREA: GENERAL ADMINISTRATION
SUBJECT: PSYCHOTHERAPY NOTES POLICY

SCOPE

UAMS Workforce

DEFINITIONS

Legal Representative means the person authorized by law to act on behalf of the patient, such as the parent of a minor, a court-appointed guardian or a person appointed by the patient in a Power of Attorney document.

Mental Health Professionals include, but are not limited to, psychiatrists, psychologists, licensed social workers, bachelor level social workers, licensed professional counselors or case workers.

Psychotherapy Notes means notes recorded (in any medium) by a health care provider who is a Mental Health Professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the patient’s medical record. Psychotherapy Notes do not include medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

Required by Law means a mandate contained in law that compels UAMS to make a use or disclosure of information and that is enforceable in a court of law. “Required by Law” includes, but is not limited to, court orders and court-ordered warrants, grand jury subpoenas, a governmental or administrative body authorized by law to require the production of the information being sought, Medicare or Medicaid conditions of participation, and statutes or regulations that require the production of the information. “Required by Law” does not mean a subpoena issued by an attorney in a private civil action.

UAMS Workforce means, for purposes of this Policy, employees, volunteers, trainees, and other persons whose conduct, in the performance of work for UAMS, are under the direct control of UAMS, whether or not they are paid by UAMS.

POLICY

All uses and disclosures of Psychotherapy Notes must be in accordance with the federal and state laws and regulations, including the federal HIPAA regulations and consistent with the procedures set forth in this Policy. Psychotherapy Notes are not a part of the patient’s medical record and are not required to be disclosed to the patient or the patient’s Legal Representative. UAMS will not disclose Psychotherapy Notes to the patient or patient’s Legal Representative without prior approval from the originator of the Psychotherapy Notes.

PROCEDURES

A. Uses and Disclosures of Psychotherapy Notes: Psychotherapy Notes may be used or disclosed for any of the following purposes:
• Use by the originator of the Psychotherapy Notes for treatment.

• Use or disclosure by UAMS for its own mental health training programs in which students, trainees or practitioners in mental health learn under supervision to practice or improve their skills in group, joint, family, or individual counseling.

• Use or disclosure by UAMS to defend itself in a legal action or other proceeding brought by the patient who is the subject of the Psychotherapy Notes.

• To investigate or determine compliance with the HIPAA regulations.

• When Required by Law.

• To a health oversight agency in connection with health oversight activities involving the originator of the Psychotherapy Notes.

• To a coroner or medical examiner for the purposes of identifying a deceased person, determining cause of death, or other duties as authorized by law.

• To prevent a serious and imminent threat to the health or safety of a person or the public.

B. **Disclosures Requiring Signed Authorization From Patient:** For all other uses and disclosures of Psychotherapy Notes, you must obtain (a) the patient’s signed Authorization using the UAMS Authorization for Release of Psychotherapy Notes form; and (b) signed approval from the Mental Health Professional who authored the notes. If the author of the Psychotherapy Notes is no longer employed by or affiliated with UAMS, and there is a reasonable basis to believe that the author is no longer available to act on a request for approval, UAMS may consult another UAMS Mental Health Professional to seek approval for such uses or disclosures of the Psychotherapy Notes still in the possession of UAMS, other than those outlined in the above section.

C. **Patient Authorization Must Be Separate Authorization Using UAMS Authorization for Disclosure of Psychotherapy Notes Form:** Authorizations for release of Psychotherapy Notes will not be combined with Authorizations for release of other PHI. In the event a patient, or patient’s Legal Representative authorized by law to act on behalf of the patient, requests a copy of Psychotherapy Notes or requests the release of Psychotherapy Notes to a third party, UAMS will use the UAMS Authorization for Disclosure of Psychotherapy Notes form. If there is a request for the release of the patient’s PHI at the same time there is a request for the release of Psychotherapy Notes, a separate HIPAA complaint authorization must be provided for the Psychotherapy Notes. UAMS will not provide or accept an authorization that combines the requests into one single authorization.

D. **Patient Access and Request for Copies:** Psychotherapy Notes are not maintained as a part of the patient’s medical record. UAMS is not required to provide patients with access to or a copy of their Psychotherapy Notes. The originator of the Psychotherapy Notes, however, may determine at his or her discretion whether to do so.

E. **Security and Storage of Psychotherapy Notes:** The Mental Health Professional who is the originator of the Psychotherapy Notes must maintain and store the Psychotherapy Notes in a secure location and manner to preclude unauthorized access or disclosure in violation of this policy or the HIPAA regulations.
UAMS ADMINISTRATIVE GUIDE

NUMBER: 3.1.18
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SECTION: GENERAL ADMINISTRATION
AREA: ADMINISTRATION
SUBJECT: REQUEST FOR ALTERNATIVE METHOD OF COMMUNICATIONS OF PROTECTED HEALTH INFORMATION

SCOPE

All UAMS Physicians, Faculty, Employees, Students and Volunteers

DEFINITIONS

Legal Representative means the person authorized by law to act on behalf of the patient, such as the parent of a minor, a court-appointed guardian or a person appointed by the patient in a Power of Attorney document.

Protected Health Information (PHI) means information that is part of an individual’s health information that identifies the individual or there is a reasonable basis to believe the information could be used to identify the individual, including demographic information, and that (i) relates to the past, present or future physical or mental health or condition of the individual; (ii) relates to the provision of health care services to the individual; or (iii) relates to the past, present, or future payment for the provision of health care services to an individual. This includes PHI which is recorded or transmitted in any form or medium (verbally, or in writing, or electronically). PHI excludes health information maintained in educational records covered by the federal Family Educational Rights Privacy Act and health information about UAMS employees maintained by UAMS in its role as an employer.

POLICY

All patients or patient’s Legal Representatives may request the University of Arkansas for Medical Sciences (UAMS) to utilize alternative methods or alternative locations for the patient or patient’s Legal Representative, or any other information from UAMS containing the patient’s Protected Health Information (PHI). UAMS will honor requests which UAMS determines to be reasonable, and UAMS does not require the patient to disclose an explanation or reason for such request. If necessary, UAMS will require the patient to identify how payments will be made.

PROCEDURE

A. Request Form: All requests for alternative methods (i.e., written or verbal) or locations (i.e., home or office) to received PHI must be submitted using the attached form signed by the patient or the patient’s Legal Representative and must be referenced in the patient’s record.

B. Department-Specific Procedures: Individual departments and other UAMS components will develop and implement procedures in compliance with this Policy. UAMS Medical Center employees should refer to the UAMS Medical Center Policy Request for Alternative Method of Communications of Protected Health Information.
EXAMPLES

Examples of requests include, but are not limited to the following:

1. Patient may request to receive mail from UAMS containing the patient’s PHI at a work address instead of home.

2. Legal guardian of patient may request communications from UAMS to be sent to adult children instead of incapacitated elderly parent.

3. Patient may request telephone communication be limited to home telephone.

Please complete this Form to request UAMS to communicate with you by alternative means or at an alternative location. For example: UAMS mail to be sent to a different address other than your home.

I, _____________________________________, request you communicate with me as indicated below:

PRINT Patient’s First and Last Name

(Print request in space provided)

- I understand this request expires on _________________. If I wish to extend my request, I must submit another request in writing to:

http://www.uams.edu/adminguide/Win03118.html
I understand that requesting this alternative method of communication may interfere with UAMS’ ability to contact me in medical emergencies.

I understand and agree that, if I cannot be located by the alternative method requested, UAMS may use any available contact information to locate me in the event that (1) UAMS determines there is a medical emergency or similar situation in which my health is at risk if I am not contacted immediately; or (2) if I have not provided adequate information on how payments will be made.

_______________________________________                         _____________________
Signature of Patient or Legal Representative                                          Date

If Legal Representative, authority of Legal Representative

(such as parent of a minor, court-appointed guardian, administrator of estate of deceased, attorney-in-fact appointed with power of attorney, or healthcare proxy)

For verification purposes, please include your date of birth: ____________ / ____ / ______.

Month        Day        Year

Patient’s telephone number (for processing the Request): _____________________

For Staff Use Only

☐ Verbal  ☐ Request Approved

☐ Request Denied If not approved, Patient was notified on ____________________________.

_______________________________________
UAMS Staff Signature and Date

NOTE: When using HBO/SMS billing systems, if the Patient and Guarantor are not the same, all billing information will continue to go to the Guarantor’s address.

EPF Bar Code HIPAA

Request for Alternative Method of Communication Form (Word document)
SCOPE

UAMS Physicians, Faculty, Employees and Volunteers.

POLICY

Unless the patient requests UAMS not to disclose Patient Directory Information, UAMS may provide Patient Directory Information to a person provided that the caller or requesting party specifies the patient name.

1. Patient Directory Information is limited to the following:
   - Patient name
   - Location in the facility
   - One word statement of condition that does not communicate specific medical information about the patient – to be released by UAMS Medical Center Patient Care Team or Office of Communications and Marketing. University Hospital and Clinical Programs Professional Nursing Organization Policy Standards, Patient Confidentiality, J.4.
   - Religious affiliation – only released to members of the Clergy

2. Patients may restrict or prohibit release of their information from the Directory.

3. UAMS may release the patient’s religious affiliation, if given to UAMS by the patient, only to members of the Clergy. Members of the Clergy do not have to specify patient name to request Patient Directory Information. Clergy requests for a list of patients by denomination will be handled by the Office of Pastoral Care at (501) 686-5410.

4. Members of the media who request Patient Directory Information will be referred to the UAMS Office of Communications and Marketing, (501) 686-8149 or (501) 395-5989 in accordance with Media Relations and Release of Information, Policy A.2.01.

UAMS may elect on its own, without a patient’s request, to exclude certain patients from the Directory and not release any information. Examples are when the safety/security of patients or others are at risk, or at the request of the UAMS Special Services Office.

PROCEDURE

1. The UAMS workforce should reference the UAMS Notice of Privacy Practices Policy to inform the patients about the information in the Directory and to describe how this information may be disclosed.

http://uams.edu/AdminGuide/Win03120.html
2. The **UAMS Notice of Privacy Practices Policy** will inform patients of their rights to omit some or all of their information for directory purposes.

3. The “Request to be Excluded from the Patient Directory” form must be maintained for patients who object to any or all of their information being included in the Directory, or if UAMS determines that the patient should be excluded. UAMS will “flag” directory listings and other applicable records to indicate exclusions have been requested.

4. Requests for a patient condition will be referred to the nursing unit except for requests from members of the media. *Media Relations and Release of Information, Policy A.2.01.*

5. Individuals who identify themselves as members of the media will be referred to the UAMS Office of Communications and Marketing.

6. All other requests for Patient Directory information at UAMS Medical Center must be provided via the HBOC Medipac **INFO (Information Desk Inquiry)** screen, the **Patient Information Screen** in OSCAR, by another officially approved mechanism, or by calling Patient Information at (501) 686-6416.

7. If the patient is incapacitated or in an emergency treatment situation, UAMS may use or disclose some or all of the information in the Directory provided the disclosure is:
   - Consistent with a known, prior expressed preference of the patient; and
   - UAMS determines it is in the patient's best interest.

   When it becomes practical to do so, UAMS will inform these patients about the uses and disclosures for Directory purposes and offer them the opportunity to decline inclusion in the Directory.

**Request to be Excluded from the Patient Directory**

If I am a patient at this facility, I understand that the following information in the facility’s Patient Directory is available to any person who asks for me by name:

(1) my name;

(2) my location in the hospital or clinic location; and

(3) a one word statement of my general medical condition (such as good, fair, serious, critical), without any other specific medical information.

I also understand that members of the clergy may receive this information, along with my religious affiliation, even if they do not ask for me by name.

**PLEASE COMPLETE ONE OF THE FOLLOWING IF YOU WISH TO RESTRICT THE RELEASE OF INFORMATION ABOUT YOU FROM THE PATIENT DIRECTORY.**

[  ] I do not wish to be included in the Patient Directory. I understand that my exclusion from the Patient Directory will keep this facility from releasing my room number or clinic location to florists, friends, and family and from transferring phone calls to my room.

OR

[  ] I agree that my name can be listed in the Patient Directory, but I want to restrict the release of the following information from the Patient Directory: (check all that apply)

[  ] Do not provide my room number or clinic location.
I understand that the above restrictions will apply only to this visit or admission, and that I **must** request restrictions again at future visits if I want any restrictions to be in effect.

Date of admission or clinic visit          Signature of patient or representative          Today’s date

**STAFF USE ONLY**

[ ] Verbal request and the patient or representative was not available to fill out this form.

[ ] If a request to exclude information from the Patient Directory is initiated by UAMS, instead of by the patient or a patient’s representative, check this box and sign/date below. ____________________________________________

_________________________UAMS employee making the request             Date

[ ] Patient or UAMS request received and documented in HBO/OSCAR.

_________________________UAMS Signature             Date

EPF Barcode          HIPAA
Definitions

**UAMS Workforce** means physicians, employees, volunteers, residents, students, trainees, visiting faculty, and other persons whose conduct, in the performance of work for UAMS, is under the direct control of UAMS, whether or not they are paid by UAMS.

Policy

Any known or suspected violations of the HIPAA regulations or related UAMS policies and procedures must be reported in accordance with this Policy.

UAMS workforce who report in good faith such known or suspected violations shall not be subjected to retaliation, intimidation, discrimination, coercion, or harassment as a result of their report.

Violations of this policy, including failure to report, will be grounds for disciplinary action up to and including termination. Any sanctions that are applied will be documented.

Procedure

Reports by patients or employees may be made to any of the following:

- UAMS Reporting Line (1-888-511-3639);
- UAMS HIPAA Office, #829, room number M1/147c, (501-614-2187);
- UAMS Research Compliance Office, (501-526-7134); or

If the employee making the report is more comfortable reporting to the head of his/her department or anyone else in a position of responsibility, he/she may do so. The person receiving this report should contact the UAMS HIPAA Office as outlined above.

References

UAMS Clinical Programs Patient Complaint Policy, PS.2.03
UAMS ADMINISTRATIVE GUIDE

NUMBER: 3.1.29
DATE: 04/01/03
REVISION: 3/1/2004

SECTION: ADMINISTRATION
AREA: GENERAL ADMINISTRATION
SUBJECT: REQUEST FOR DATA EXTRACTS

SCOPE

UAMS workforce

DEFINITIONS

Disclosure means the release, transfer, provision of access to, or divulging of information in any manner (verbally or in writing) by UAMS to persons who are not UAMS employees or students, or to any other person or entity OUTSIDE of UAMS.

Fundraising means any activity relating to the efforts of raising funds for the institution of UAMS and its related health care facilities.

Minimum Necessary means limiting Protected Health Information to the minimum necessary to accomplish the intended purpose of the use, disclosure or request.

Protected Health Information (PHI) means information that is part of an individual’s health information that identifies the individual or there is a reasonable basis to believe the information could be used to identify the individual, including demographic information, and that (i) relates to the past, present or future physical or mental health or condition of the individual; (ii) relates to the provision of health care services to the individual; or (iii) relates to the past, present, or future payment for the provision of health care services to an individual. This includes PHI which is recorded or transmitted in any form or medium (verbally, or in writing, or electronically). PHI excludes health information maintained in educational records covered by the federal Family Educational Rights Privacy Act and health information about UAMS employees maintained by UAMS in its role as an employer.

UAMS Workforce means for purposes of this Policy, physicians, employees, volunteers, trainees, and other persons whose conduct, in the performance of work for UAMS, are under the direct control of UAMS, whether or not they are paid by UAMS.

POLICY

When a member of the UAMS workforce requests access to any PHI stored electronically concerning a group of patients in order to create a separate database or “data extract” for a use or disclosure permitted by the HIPAA regulations, UAMS will undertake reasonable efforts to limit access to the PHI in the data extract to the Minimum Necessary to carry out the duties of the workforce member or to the amount reasonably necessary to achieve the purpose of the disclosure.

All such uses or disclosures of data extracts containing PHI must be in compliance with UAMS policies, federal and state law, and HIPAA regulations.
UAMS will identify those persons and job titles authorized to perform searches of data to produce and receive data extracts. Periodic audits to determine compliance with this Policy will be conducted.

**PROCEDURE**

A. UAMS Information Technology Department will maintain an inventory of databases containing PHI.

B. UAMS workforce members seeking an electronically stored data extract containing PHI must complete a "Request for Data Extract" and submit it to the UAMS custodian of the data who must be authorized by UAMS to perform searches of data to produce extracts. A form is available for your convenience.

C. The following information must be included in the request:

1. Name, job title and phone number.
2. Complete description of data required including time periods, specific search criteria and other information needed from the database.
3. Entities or individuals for whom the use or disclosure of the PHI is required.
4. The purpose of the use or disclosure of the data requested.
5. “Yes” and “no” boxes for the requestor to indicate:
   a. Is the requestor a Principle Investigator or Research Assistant?
   b. If the data will be used for research, has an appropriate patient authorization been obtained or has an IRB waiver of authorization been granted?
   c. If the data requested is to conduct research on deceased individuals, is the Certification for Use or Disclosure of Protected Health Information for Deceased Individuals form current and on file in the UAMS Office of Research and Sponsored Programs.
   d. If the data is to be used for Review Preparatory to Research, is the Certification for Use or Disclosure of Protected Health Information for the Purpose of Review Preparatory to Research form current and on file in the UAMS Office of Research and Sponsored Programs.
6. Statement that the requesting party certifies that the information requested is the Minimum Necessary to carry out his or her job duties; or if the request is for a disclosure of PHI, a statement that the requesting party certifies that the information requested is the Minimum Necessary to accomplish the purpose of the disclosure.
7. Any other information requested by the custodian of the database. A custodian may request completion of a “Request for Data Extract” form.

D. If the purpose of the data request is for research or review preparatory to research and the appropriate boxes under (C)(5)(b) through (C)(5)(d) above are not marked “yes,” the request must be denied. If the purpose of the data request is a use or disclosure that is not permitted by the UAMS policies, federal or state law, and the HIPAA regulations, the request must be denied.

E. Request for Information for Fundraising Purposes: UAMS will use only the following information for Fundraising purposes. See UAMS Use and Disclosure of PHI for Fundraising Policy, 3.1.35

1. a patient’s demographic information; and
2. dates of health care services provided to the patient.

No other PHI may be used or disclosed by UAMS for Fundraising purposes without the patient’s signed authorization using the UAMS Authorization for Use/Disclosure of PHI for Fundraising Form.

F. The UAMS personnel providing the data extract shall record the date the extract was given to the requesting party and shall maintain a copy of the Request for a minimum of six years from the date of the request.

G. UAMS may rely, if such reliance is reasonable under the circumstances, on a requested use as the Minimum Necessary for the stated purpose when the information is requested by a professional who is a member of the UAMS workforce if the professional represents that the information requested is the Minimum Necessary to...
carry out his or her job duties; or if the request is for a disclosure of PHI, UAMS may rely on representations from the person requesting the information that the information requested is the Minimum Necessary to accomplish the purpose of the disclosure.

H. For all requests of data extracts containing PHI that will be disclosed outside of UAMS, the UAMS HIPAA Office must approve these requests, including requests by individuals who are not members of the UAMS workforce.

I. Knowledge of a violation or potential violation of this policy must be reported. Refer to UAMS Reporting Policy for HIPAA Violations, 3.1.23.

J. Disciplinary action may be imposed for accessing, using, or disclosing PHI in violation of this policy.

For a printable version of the form below, please see the Request for Data Extract Word document.

UAMS REQUEST FOR DATA EXTRACT FORM

All of the information below must accompany all requests for data extracts that contain identifiable patient information.

Requestor’s Name

Requestor’s Job Title _____________________________ Phone # _____________________________

Description of data required (include time periods, specific search criteria, etc.): _____________________________

____________________________________________________________________________________

____________________________________________________________________________________

Entities and/or individuals for whom the use or disclosure of PHI is required: _____________________________

____________________________________________________________________________________

____________________________________________________________________________________

It is the policy of UAMS to protect the privacy and security of a patient’s Protected Health Information (PHI).

http://uams.edu/AdminGuide/Win03129.html

11/3/2005
Purpose of the use or disclosure of the requested data: ________________________________

____________________________________________________________________________________

____________________________________________________________________________________

• Is the requestor a Principal Investigator?  □ yes  □ no

• If data will be used for research, has an appropriate patient authorization been obtained or has an IRB waiver of authorization been granted?  □ yes  □ no  □ N/A

  **If “no”, you must submit the appropriate authorization or waiver before requested data can be released.**

• If the data requested is to conduct research on deceased individuals, is the Certification for Use or Disclosure of Protected Health Information of Deceased Individuals form current and on file in the UAMS Office of Research and Sponsored Programs, #636  □ Yes  □ No  □ N/A

• If data requested is to be used for Review Preparatory to Research, is the Certification for Use or Disclosure of Protected Health Information for the Purpose of Review Preparatory to Research form current and on file in the UAMS Office of Research and Sponsored Programs, #636  □ Yes  □ No  □ N/A

I am a member of the UAMS workforce and certify that the information requested is the minimum necessary to carry out job duties/accomplish research goals and will be used for the purpose stated above. I am making this request in compliance with the UAMS Minimum Necessary Policy 3.1.25 and, if applicable, with Research Policy 3.1.27.

http://uams.edu/AdminGuide/Win03129.html
UAMS ADMINISTRATIVE GUIDE

NUMBER: 3.1.38
DATE: 10/01/2003
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SECTION: ADMINISTRATION
AREA: GENERAL ADMINISTRATION
SUBJECT: SAFEGUARDING PROTECTED HEALTH INFORMATION

SCOPE

UAMS Workforce with Access to Confidential Information, including Electronic Protected Health Information (ePHI), for any purpose.

DEFINITIONS

Confidential Information includes information concerning UAMS research projects, confidential employee information, information concerning the UAMS research programs, proprietary information of UAMS, and sign-on and password codes for access to UAMS computer systems. Confidential information shall include Protected Health Information.

Electronic Media means:

(1) Electronic storage media including memory devices in computers (hard drives) and any removable/transportable digital memory medium, such as CD-ROM, DVD, floppy disks, magnetic tape or disk, optical disk, or digital memory card; or

(2) Transmission media used to exchange information already in electronic storage media. Transmission media include, for example, the internet (wide-open), extranet (using internet technology to link a business with information accessible only to collaborating parties), leased lines, dial-up lines, private networks, and the physical movement of removable/transportable electronic storage media. Certain transmissions, including of paper, via facsimile, and of voice, via telephone, are not considered to be transmissions via electronic media, because the information being exchanged did not exist in electronic form before the transmission.

Electronic Protected Health Information (ePHI) means individually identifiable health information that is:

- Transmitted by Electronic media
- Maintained in Electronic media

Information System means an interconnected set of information resources under the same direct management control that shares common functionality. A system normally includes hardware, software, information, data, applications, communications, and people.

Pre-Research or Review Preparatory to Research means the review of information or records prior to obtaining patient authorization and consent or prior to obtaining an IRB Waiver of Authorization in which the review is solely to prepare a research protocol, to determine if a research project is feasible, or for similar purposes preparatory to research.

Protected Health Information (PHI) means information that is part of an individual’s health information that identifies the individual or there is a reasonable basis to believe the information could be used to identify the
individual, including demographic information, and that (i) relates to the past, present or future physical or mental health or condition of the individual; (ii) relates to the provision of health care services to the individual; or (iii) relates to the past, present, or future payment for the provision of health care services to an individual. This includes PHI which is recorded or transmitted in any form or medium (verbally, or in writing, or electronically). PHI excludes health information maintained in educational records covered by the federal Family Educational Rights Privacy Act and health information about UAMS employees maintained by UAMS in its role as an employer.

**UAMS Workforce** means physicians, employees, volunteers, residents, students, trainees, visiting faculty, and other persons whose conduct, in the performance of work for UAMS, is under the direct control of UAMS, whether or not they are paid by UAMS.

For additional definitions: [http://hipaa.uams.edu/DEFINITIONS%20-%20HIPAA.pdf](http://hipaa.uams.edu/DEFINITIONS%20-%20HIPAA.pdf)

**POLICY**

UAMS workforce must undertake appropriate administrative, technical and physical safeguards, to the extent reasonably practicable, to preclude Protected Health Information (PHI) from intentional or unintentional use or disclosure in violation of the HIPAA regulations.

Electronic Protected Health Information (ePHI) and other confidential information located on UAMS Information Systems or Electronic Media must be protected against damage, theft, and unauthorized access. This includes all ePHI and confidential information received, created, maintained and transmitted by UAMS. Confidential information must be consistently protected and managed through its entire life cycle, from origination to destruction. Controls must be in place for hardware and Electronic Media moving into, out of, and within UAMS. Information Systems and Electronic Media for which this policy applies include, but are not limited to, computers (both desktop and laptop), floppy disks, backup tapes, CD-ROMs, zip drives, portable hard drives and PDAs.

**PROCEDURE**

While access to PHI, and conversations regarding a patient, often must occur freely and quickly in treatment settings, the following safeguards should take place to the extent reasonably practicable:

**A. Protecting Printed Information:**

1. Route incoming written correspondence through the smallest number of viewers possible.
2. Pre-address all envelopes to individuals or specific departments within UAMS.
3. Keep photocopying of documents containing PHI to a minimum.
4. Shred or place unneeded copies containing PHI in a security bin.
5. Any documents containing PHI should be placed with identifying information face down on counters, desks, and other places where patients or visitors might see them. These documents should not be left out on desks or countertops after business hours and should be placed in locked storage bins, locked desk drawers, or other secure areas.
6. When discarding records or items containing PHI, use a shredder or place the records and items in a bin specifically designated as a shredding bin where the records and items will be retrieved for shredding. All shredding bins should be placed in an area where unauthorized persons cannot easily view or access the PHI contained in the shredding bin.
7. When paper documents are in transit from location to location, place the documents in sleeves, bags, or envelopes that are sealed and clearly addressed to the recipient.
8. When transporting medical records, they should never be left unattended and records should be covered or turned over so that PHI is not visible to casual observers.

9. IV bags and other medically related material that is not suitable for shredding and is placed in regular trash should have all patient identifiers removed or obliterated.

10. Locate fax machines in non-public areas. Refer to UAMS Faxing of PHI and Other Confidential Information Policy, 3.1.19.

B. Bulletin Boards:

Bulletin boards located in areas that may be seen by patients or visitors should not contain any documents containing PHI, unless the patient has agreed to the display by written or documented verbal permission. This would include baby pictures, cards and notes of appreciation and children’s signed art work.

C. Storage of Paper-Based Data:

1. After business hours or when not in use by authorized personnel, documents or items containing PHI should be supervised or kept in a locked desk, locked cabinet or other locked location. Storage of documents containing PHI, whether on-site or off-site, must be locked at all times except during use by authorized personnel.

2. Limit the number of keys given to employees. Provide keys to areas and locked cabinets to only those employees whose job responsibilities require or necessitate access to the areas or cabinets where PHI is stored or located.

3. Limit access to filing areas and off-site storage facilities where records or items containing PHI are located to only those employees whose job responsibilities require access to such areas.

D. Shredders:

1. Place shredder machines in a convenient location. If you plan to purchase a shredder, a “cross-cut” shredder is recommended as the security standard.

2. Encourage all staff to use the shredder machines.


E. Outsourcing Shredding:

1. Contract with a reputable vendor.

2. Agree upon acceptable timeframes between pick up and destruction.

3. Review the security of containers in which paper is transported off the site.

4. Monitor the vendor’s performance regularly.

G. Physical Security:

1. All persons (patients, visitors, vendors and others) who are not authorized to have access to PHI should
be supervised, escorted or observed when visiting or walking through an area where PHI may be easily viewed or accessed.

2. Utilize a system of controlling the distribution of keys. Require all employees to return all keys upon the effective date of termination of their employment with UAMS, or when the job responsibilities of the employee no longer require access to the areas or cabinets accessed by the key or keys.

3. Doors should be locked at night, unless authorized personnel need access to the rooms or areas after hours.

4. Access to areas containing PHI should be monitored and controlled to the extent possible.

I. Conversations:

1. Conversations with a patient and other conversations in which PHI is being discussed, over the phone or in person, should be made, to the extent possible, in a manner or in a location (or both) where persons who are not intended to be a part of the conversation or who are not authorized to receive the PHI cannot easily overhear the conversation.

2. When having a conversation in a public area with a patient, the patient’s family members, or other conversations in which PHI is discussed, conduct the conversation in a lowered voice, to the extent possible, so that unauthorized persons cannot easily overhear the conversation.

3. Avoid using patients’ names or the names of patients’ family members in public hallways and elevators when persons who are not authorized to receive the information are present.

4. In an emergency situation, where a patient is hearing impaired or in other situations where the ability to discuss PHI quietly and in private may not be practicable, take reasonable precautions to preclude the disclosure of PHI to the extent possible.

J. Paging:

1. Overhead paging of patients and patients’ family members should be kept to a minimum. Only request the page if it is urgent and you are unable to locate the patient or family by other means.

2. Only the minimum amount of information should be used when paging. For example, “Mr. John Jones, please return to surgery waiting room.”

3. Do not request overhead pages for patients who have asked to be omitted from the patient directory.

K. X-Ray Lightboards and Nursing Station Whiteboards:

Place all X-ray lightboards and nursing station whiteboards in an area generally not accessible by the public or readily visible to the public, or implement other safeguards which reasonably limit incidental disclosures to the general public.

L. Sign-In Sheets:

Information on patient sign-in sheets should only include the patient’s name and appointment date and time. Do not include unnecessary information such as patient complaint, date of birth, or other information that is not necessary for the sign-in sheet. Use of peel-off labels for patient’s to sign, which are then transferred to a sign-in sheet kept outside the view of other patients, is preferable to a sign-in sheet in view of other patients.

M. Charts in Chart Holders Outside Exam Room:
When placing patient records in chart holders outside of examination rooms, turn the records with the front cover facing the wall or with identifying information otherwise covered, so the patient’s information is not visible to passersby.

N. **Voice Mail/Answering Machine Messages:**

1. When leaving a voice mail or answering machine message for a patient, always limit the amount of information disclosed to the minimum necessary, such as the provider name and telephone number, or other information necessary to confirm an appointment, or to ask the individual to call back. For example, when confirming an appointment, the information should be limited to appointment date and time, the doctor’s name, and a contact name and telephone number.

2. **Do not** leave messages that include laboratory and test results, or any other information that links a patient's name to a particular medical condition or the type of clinic or specialist the patient is seeing. (For example, "I am calling to remind Mrs. Brown of her chemotherapy treatment tomorrow at 10:00," is not an appropriate message.)

3. Generally, when leaving a message with a family member or friend answering the patient’s phone, the message should be limited to a request for the patient to return your call; and you may leave your name, telephone number, and the fact that you work at UAMS.

4. A patient's verbal permission or written authorization is NOT needed in these circumstances when leaving a message for the patient as directed by this policy and procedure.

O. **E-Mail:**

All e-mail messages must include a confidentiality statement, including messages sent internally or outside UAMS, and regardless of whether the e-mail message contains PHI. Refer to UAMS *E-Mail Access and Usage Policy, 7.1.12.*

P. **Faxing:**

For documents containing PHI that are faxed internally or outside UAMS, please refer to the UAMS *Faxing Protected Health Information or Other Confidential Information Policy, 3.1.19.*

Q. **Safeguarding ePHI and other Confidential Information in Electronic Format**

1. Access to ePHI is through user authentication and password.

2. Access to Information Systems and Electronic Media containing ePHI and other confidential information at UAMS must be provided only to authorized UAMS workforce members who have a need for specific access in order to accomplish a legitimate task. UAMS workforce members must not attempt to access, duplicate or transmit Electronic Media containing ePHI and other confidential information for which they do not have appropriate authorization. Refer to *Information Access Management Policy, 7.3.04* and *Confidentiality Policy, 3.1.15.*

3. User access may require specific training depending on the system before access is allowed.

4. UAMS Electronic Storage Media such as, CDs, diskettes and DVDs that contain ePHI should be clearly marked as confidential.

5. UAMS Information Systems and Electronic Media containing ePHI or other Confidential Information should be located and stored in secure environments that are protected by appropriate...
6. UAMS Information Systems and Electronic Media containing ePHI and other confidential information must be disposed of properly when no longer needed.

   a. Electronic Media containing ePHI or other Confidential Information that is to be disposed of permanently must be physically destroyed, and may be accomplished in one of the following ways:
      i. Break diskettes or otherwise render it impossible to re-insert it into a PC drive
      ii. Punch a hole through the entire diskette
      iii. Cut CDs into pieces with standard tin-snips
      iv. Request destruction of CDs and diskettes by a shredding company contracted with UAMS to destroy diskettes and CDs
      v. Hard drives and tapes are to be destroyed by UAMS IT Department or its designee. Contact UAMS Technical Support with questions regarding disposal.

   b. Disposal of UAMS Information Systems and equipment containing ePHI must be tracked and logged. At a minimum, such tracking and logging must provide the following information:
      i. Date of disposal
      ii. Who performed the disposal
      iii. Brief description of media or Information Systems that was disposed

   c. ePHI should be removed from equipment or Information Systems that are being returned to the vendor. If that is not possible, a Business Associate Agreement must be in place before the equipment is returned to the vendor. Contact UAMS Office of Contract Services for more information about Business Associate Agreements.

7. ePHI on UAMS Electronic Media must be removed before such electronic media can be re-used.

8. UAMS Workforce members moving UAMS Information Systems and Electronic Media containing Confidential Information, including ePHI, into, out of, and within the workplace must maintain records of such movement.
1. Confidential Information, including PHI, is not to be removed from UAMS by members of the Workforce without prior approval and a signed confidentiality agreement on file. For employees who work from home part-time or full-time in an official UAMS Capacity refer also to UAMS Administrative Guide *Working from Home Policy 3.1.40*.

2. The Workforce member is responsible for maintaining the privacy and security of all Confidential Information that they may be transporting, storing or accessing off-site. This includes, but is not limited to:
   a. Protected Health Information and Electronic Protected Health Information
   b. Computers that contain or access Confidential Information.
   c. Printed documents that contain Confidential Information.

3. UAMS policies are in effect whether the Workforce member is working off-site or in a UAMS facility and include the following requirements:
   a. Electronic media and printed information must be transported and stored in a secure manner.
   b. The printing of confidential information from home computers should be kept to a minimum and only as needed in accordance with UAMS policies.
   c. All media containing PHI or ePHI must be disposed of appropriately and must never be placed in regular trash. This includes printed information, faxes, hard drives, diskettes and CDs.
   d. UAMS materials must be put away when not being used and kept in a secure location that is not accessible to others including children, spouse and visitors.
   e. Passwords must not be shared or accessible to family members or others
   f. Any Confidential Information or ePHI sent from workstations, laptops, PDAs and other mobile devices must be encrypted. Refer to *Mobile Device Safeguards Policy 3.1.17*.
   g. Anti-virus software must be installed on all home computers and mobile devices used for UAMS business, and they must be password protected.
   h. Employees are required to maintain updates to current operating systems (ex. Microsoft updates/patches)
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SCOPE

UAMS Workforce

DEFINITIONS

**Designated Record Set** means (i) medical records and billing records; (ii) records used, in whole or in part, to make decisions about patients; and (iii) the enrollment, payment, claims adjudication, and case or medical management record systems.
Disclosure means the release, transfer, provision of access to, or divulging of information in any manner (verbally or in writing) by UAMS to persons who are not UAMS employees or students, or to any other person or entity OUTSIDE of UAMS.

Health Care Operations is defined by the HIPAA regulations under 45 C.F.R. § 164.501 and is incorporated herein by reference, and includes the following:

1. Quality assessment and improvement, including outcomes evaluation and development of clinical guidelines; population-based activities relating to improving health or reducing health care costs, protocol development, case management and case coordination, contacting providers and patients with information about treatment alternatives; and related functions that do not include treatment.

2. Accreditation, certification, licensing or credentialing activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs in which students, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as health care providers, training of non-health care professionals.

3. Conducting or arranging for medical review, legal services and auditing.

4. Business planning and development related to managing and operating the entity.

5. Business management and general administrative activities, such as fundraising and marketing of services to the extent permitted without Authorization, disclosure of PHI in a due diligence review or to resolve internal grievances, and customer service.

POLICY

It is the policy of UAMS to protect the privacy and confidentiality of all patient medical records and information contained in the medical records, including the patient’s Protected Health Information (PHI), in accordance with applicable state and federal laws and ethical standards. UAMS prohibits persons not authorized by law to obtain access to or copies of a patient’s PHI and medical records. UAMS will provide a patient access to, and the right to obtain a copy of, his or her PHI in the patient’s Designated Record Set at UAMS for as long as it is maintained in the Designated Record Set and in accordance with this Policy.

Medical records of UAMS patients which are maintained by UAMS, recorded in any form, including data recorded on paper, microfilm, in a computer database or any other medium (e.g., photographs, x-ray films, ECG tracings, videotapes) constitute the property of UAMS. UAMS prohibits the removal of any original medical records from UAMS premises, unless the records are ordered by a court of law or other government authority to be produced in the original form.

A. Verification of Identity/Authority:

1. Identity: In all circumstances, verify the identity of the person to whom you are disclosing PHI, if the person’s identity is not known to you, including the identity of the patient. Exception: Patient Directory – If the patient has not opted out of the patient directory, very limited information about the patient may be provided to any person who identifies the patient by name. See “Patient Directory” Section 9 in this Policy, UAMS Patient Directory Policy, 3.1.20, and 3.1.37 Verification of Identity Policy 3.1.37 for more information.

2. Authority: Except for the circumstance described above under “Patient Authorization” (when patient has signed Authorization form), verify the authority of the person to request a patient’s PHI, or to request that a patient’s PHI be disclosed to someone else, if the authority is not known to you. A patient has the authority to request disclosures by virtue of being a patient, and therefore, only a patient’s identity must be verified. Refer to Section 9 in this Policy to see elements of a valid HIPAA Authorization.

http://uams.edu/AdminGuide/Win03128.html

11/3/2005
3. Patient Authorization Using UAMS Authorization Form: If a patient has signed a valid HIPAA authorization or approved UAMS Authorization form to disclose his/her PHI to someone else, then you can follow the Authorization. It is not necessary to verify the authority of the person designated by the patient to receive the information. If a patient’s legal representative has signed the UAMS Authorization Form, however, the legal representative’s authority must be verified. See “Disclosures to Patient’s Legal Representative” and “Patient Authorization Form” set forth in this Policy for more information.

B. Minimum Necessary Policy: All uses and disclosures of PHI must be made in accordance with the UAMS Minimum Necessary Policy, 3.1.25.

SECTION 1 – DISCLOSURES TO THE PATIENT – No Patient Authorization Required.

In general, a patient’s PHI may be disclosed to the patient, verbally or in writing, without the requirement of any patient authorization. If the patient is not known to you, you must verify the identity of the patient prior to disclosing any information.

Subject to the restrictions and procedures stated in this Policy, a patient has the right to inspect or obtain a copy of their medical records, or PHI maintained in a Designated Record Set, except for the following:

1. Psychotherapy notes as defined in this Policy;
2. Information compiled in, or for use in, a civil, criminal or administrative action or proceeding; or
3. PHI that is subject to the Clinical Laboratory Improvements Amendments of 1988 (CLIA).

See “Patient Request for Access To Or A Copy Of Medical Records” set forth in this Policy for more information.

SECTION 2 – FOR UAMS TREATMENT, PAYMENT AND OPERATIONS – No Patient Authorization Required.

PHI may be used or disclosed without patient authorization for our own Treatment, Payment and Health Care Operations as defined herein. Such use and disclosure, however, is subject to the requirements of the UAMS Minimum Necessary Policy (limiting the use or disclosure of PHI to the minimum necessary) and the UAMS Patient Restriction Request Policy (allowing the patient to restrict the use or disclosure of PHI in certain circumstances). The identity and authority of the person requesting or receiving the PHI must be verified.

SECTION 3 – TO ANOTHER HEALTH CARE PROVIDER OR COVERED ENTITY – No Patient Authorization Required.

A. To Other Health Care Provider or Covered Entity for Treatment or Payment: UAMS may disclose a patient’s PHI, without patient Authorization, to any other health care provider for the treatment and payment activities of that provider which relate to the patient who is the subject of the PHI disclosed, regardless of whether the health care provider is or is not a Covered Entity.

B. To Other Health Care Provider or Covered Entity for Operations: UAMS may disclose PHI, without patient Authorization, to any other provider for health care operations of that provider, regardless of whether the provider is or is not a Covered Entity, only if:

1. the provider either has or had a relationship with the individual who is the subject of the PHI being requested; and
2. the PHI pertains to such relationship; and
3. the disclosure is for the purpose of the provider’s health care operations listed in the Definition of “Health Care Operations” described in Parts (1) and (2) this Policy.
C. To a Provider in Organized Health Care Arrangement: In addition to the disclosures allowed to other providers or covered entities as described above, if the provider/covered entity participates with UAMS in an Organized Health Care Arrangement (as defined by HIPAA), UAMS also may disclose PHI, without patient authorization, to the provider/covered entity for the purpose of any health care operation activities of the Organized Health Care Arrangement.

SECTION 4 – PATIENT REQUEST FOR ACCESS TO OR A COPY OF MEDICAL RECORDS -- No Patient Authorization Required

A. General Policy Relating to Patient’s Request for Access To or Copy of Record:

Subject to the restrictions and procedures stated in this Policy, an adult or emancipated minor patient has the right to inspect or obtain a copy of their medical records, or PHI maintained in a Designated Record Set, except for the following:

- Psychotherapy Notes as defined in this Policy;
- Information compiled in, or for use in, a civil, criminal or administrative action or proceeding; or
- PHI that is subject to the Clinical Laboratory Improvements Amendments of 1988 (CLIA).

1. Viewing or copying of current admission records while an inpatient: Subject to the requirements of this Policy, nursing staff or clinicians may allow patients to view or have a copy of their records as follows:

   a. Patients may view their current admission records, as long as:

      1.1 The physician is notified and approves the viewing; and

      1.2 The patient has signed a UAMS Authorization form. Although the use of the Authorization form is not required for a patient to view his/her own record, it is the preferred method. UAMS must also accept a written request from the patient, or documentation of such request, and response to the request must be made in the patient’s progress notes.

   b. Patients may have a copy of their current admission records, as long as a written request from the patient is obtained, and documentation of such request and response to the request is made in the progress notes. The patient should be referred to Health Information Management/Medical Records Department to process the patient’s request for copies. The physician should be notified before copying current admission records. The records will be copied according to this Policy and the HIM/Medical Records Department Release of Information policy.

   c. NOTE: Physicians and nurses, using their professional judgment, may provide a patient with a copy of any portion of their records, such as diagnostic results, progress notes, or other records, without requiring the patient to obtain the records from HIM/Medical Records Department. In that event, the physician, nurse or other personnel should document in the patient’s progress notes the patient’s request and the records provided.

2. Requests for Access/Copy While an Outpatient: Subject to the requirements of this Policy, if patient requests an outpatient clinic or service area to provide access to or a copy of the patient’s medical record, the clinic or service area may provide access to or a copy of the record to the patient, under the following circumstances:

a. The patient is requesting only information from the most recent service or diagnostic reports associated with the most recent service; and

b. The patient is requesting information only from that clinical service area; and

c. The patient has provided a written request for the records, or the clinic has made a note in the patient’s medical record identifying the records provided to the patient.

Outpatient areas are not to copy or print from any protected health information source from a previous date of service or from a different clinic for release to the patient.

All requests for previous information or information from another clinical service should be forwarded to the Health Information Management/Medical Records Department. Components of UAMS should forward requests to the designated area of their facility.

3. **Never Leave Patient Alone With UAMS Record:** When providing a patient or family member access to the patient’s medical record, a designated UAMS employee must be present at all times to protect the integrity and confidentiality of the information. Items may not be added to or removed from the medical record.

4. **Questions Regarding Treatment or Amendment of Record:** All questions regarding treatment must be forwarded to the physician. If the patient wants to make an amendment to correct information in his/her medical record, an Amendment Request form must be completed in accordance with UAMS Patient’s Request to Amend Medical Records or PHI, 3.1.32.

5. **Viewing or copying of patient’s previous medical records:** Refer to Medical Records Department and Written Request Required. If a patient requests access to or a copy of his/her medical records, or PHI maintained in a Designated Record Set, the patient will be referred to Health Information Management/Medical Records Department and the request for such records must be in writing. The records will be copied according to this Policy and the HIM/Medical Records Department Release of Information policy. Requests to review medical records in person require an advance appointment.

**Family of Patient Viewing or Having Copy of Medical Record:** If the patient is requesting that family or another designee view or have a copy of the patient’s record while patient is an inpatient or outpatient, an Authorization form must be signed by the patient. See the attached Authorization for Access to and Release of Information Form. See also “Disclosures to Spouse/Family/Friends Involved in Patient’s Care” section of this Policy.

**C. Timeliness of Response to Request for Access To or Copy of Record:** UAMS will act on a request for access to or a copy of a medical record within thirty (30) days after receipt of the request if the record is held or is accessible on site, or within sixty (60) days if it is not accessible on site. This time limit may be extended for an additional thirty (30) days if UAMS sends the person a written statement of the reason for the delay and the date when the party can have the information. UAMS should date-stamp the first page of any written request or otherwise indicate when the request was received by UAMS. All written requests and authorizations must be stored in the patient’s record. Even if UAMS receives duplicate requests, all such requests must be stored in the patient’s record.

1. If the request is granted, in whole or in part, UAMS will inform the requesting party of acceptance and provide the access requested.

2. If the request is denied, in whole or in part, UAMS will provide a written denial to the patient in accordance with this policy.

**D. Denial of Access/Copy Without Opportunity to Review:** UAMS may deny access to or a copy of PHI without providing an opportunity for the patient or personal representative to review the denial in the following circumstances:
1. The PHI is exempt from right to access as set forth in Section 6A.1 above.

2. An inmate’s request to obtain PHI, if obtaining such information would jeopardize the health, safety, security, custody, or rehabilitation of the inmate or other inmates, or the safety of any officer, employee, or other person at the correctional institution or the person transporting the inmate.

3. The PHI was created or obtained during a research study that involves treatment of the patient and the patient agreed not to access the PHI until the study is concluded.

4. If UAMS received the PHI from someone other than a health care provider and promised to keep the PHI confidential and allowing access would be likely to reveal the source of the information.

E. Denial of Access/Copy with Opportunity to Review: In the following circumstances, UAMS may deny access to or a copy of PHI. However, the patient has the right to have the denial reviewed by a licensed health care professional designated by UAMS, who was not involved in the original decision to deny the request.

1. Requests for information that UAMS reasonably believes is likely to cause substantial harm or to endanger the physical safety or life of the patient or another person.

2. Requests made by a personal representative where the access is reasonably likely to cause substantial harm to the patient or another person.

F. Response to Patient if Request to Access/Copy is Denied: UAMS will comply with the following when denying access to PHI:

1. If possible, exclude the parts to which UAMS has grounds to deny access and allow access to the rest of the PHI.

2. Provide a timely written denial to the requesting party containing:
   a. The basis for the denial;
   b. A statement of the patient’s review rights, including a description of how the patient may exercise such review rights; and
   c. A description of how the patient may complain to the hospital as specified in its Notice of Privacy Practices or to the Secretary of DHHS.

3. If UAMS does not maintain the records but knows where the information is maintained, UAMS will inform the patient where to direct the request for access.

4. UAMS will refer any request for a review to the designated licensed health care professional who will, within a reasonable time, determine whether or not to uphold the denial.

5. UAMS will promptly provide written notice of the review decision to the patient or take other action as required.

SECTION 5 – DISCLOSURES TO PATIENT’S LEGAL REPRESENTATIVE – No Patient Authorization Required, but Must Be Authorized By Law.

A. Patient’s Legal Representative: Except as provided by this Policy, UAMS must treat a patient’s Legal Representative as the patient for purposes of the use and disclosure of the patient’s PHI. The following determinations must be made in considering whether a person is a Legal Representative authorized by law to act on behalf of the patient:
1. The person is authorized by law to act on behalf of the patient in connection with the patient’s health care decisions, such as:

a. Parent of their minor child; - See “Minors” Section of this Policy
b. Court-appointed Guardian of a minor;
c. Court-appointed Guardian of an elderly or incapacitated person;
d. Appointed by the patient to act as their attorney-in-fact in a Durable Power of Attorney with health care rights;
e. Appointed by the patient in a Health Care Proxy;
f. A person authorized by Ark. Code Ann. § 20-9-602 to verbally or otherwise consent to treatment/procedures suggested/directed by physician for the following persons of “unsound mind”:
   1) adult sibling of the patient of unsound mind; or
   2) spouse of the patient of unsound mind; or
   3) adult child for parent of unsound mind.
g. Court-appointed Administrator or Executor or Personal Representative of the Estate of a deceased patient. A guardianship or a power of attorney (or any other grant of authority by the patient) are no longer effective upon death. No will is effective until probated.
h. For persons who are terminally ill or permanently unconscious – see Ark. Code Ann. 20-17-202;
i. For Incapacitated persons for whom there is no health care proxy or other authority, see to Ark. Code Ann. 20-17-214.

B. Verification of Identity/Authority: UAMS will request verification of the identity of the Legal Representative, if not known, and the authority of the Legal Representative to act on behalf of the patient, if not known. If no evidence of his/her authority is available in the record or otherwise, such as a copy of the court order, the Power of Attorney or any other written documentation evidencing their authority, UAMS will request a copy from the Legal Representative.

C. Do Not Provide PHI if Suspected Harm by the Representative: A provider is not required to treat a person as the Legal or Personal Representative of the patient for purposes of disclosing PHI if the provider has a reasonable belief that the patient has been or may be subjected to violence, abuse or neglect by the person acting as a Legal/Personal Representative, or it could endanger the patient, or it is not in the best interest of the patient.
A. **Verification of Identity:** The identity of the patient and the person receiving the PHI must be verified. In making verification decisions in these particular circumstances, UAMS may rely on the exercise of professional judgment of its staff to determine a person’s identity.

B. **When Patient Present (in person or on phone):** Can disclose to Spouse, Family or Friends only under the following circumstances:

1. If the spouse, family or friend is identified by the patient; and
2. The spouse, family or friend is involved in the patient’s care; and
3. One of the following circumstances exists:
   a. Patient has agreed (verbally on phone or otherwise); or
   b. Patient does not object when provided opportunity to do so; or
   c. You can reasonably infer from circumstances that the patient does not object (such as when patient brings family member into examination room); or
   d. There is a medical emergency.

PHI disclosed in these circumstances must be limited to PHI that is directly relevant to person’s involvement with the patient’s care or payment; or to notify them of patient’s location, one word statement of general condition, or death.

C. **When Patient is NOT Present (in person or on phone), then we may:**

1. Disclose (by phone or otherwise) to spouse/family/friends involved in patient’s care PHI that is directly relevant to the person’s involvement with the individual’s health care or payment if we determine that disclosure is in the best interest of the patient.
2. Allow person to pick up filled prescriptions, medical supplies, X-rays or other similar forms of PHI, using professional judgment and experience with common practice to make reasonable inferences of the patient’s best interest in allowing a person to act on behalf of the individual.

D. **When Patient Cannot Agree/Object Because of Patient’s Incapacity or an Emergency Circumstance, then we may:**

1. Disclose [by phone or otherwise] the PHI permitted for the facility directory (name, location and one word statement of general condition), but only if this is consistent with a prior expressed preference of the patient and it is in the patient’s best interest to do; and
2. Disclose [by phone or otherwise] to spouse/family/friends involved in patient’s care PHI that is directly relevant to the person’s involvement with the individual’s health care or payment if we determine that disclosure is in the best interest of the patient; and
3. Allow person to pick up filled prescriptions, medical supplies, X-rays or other similar forms of PHI, using professional judgment and experience with common practice to make reasonable inferences of the patient’s best interest in allowing a person to act on behalf of the individual.
SECTION 7 – PATIENT AUTHORIZATION FORM.

Except as stated in this Policy and consistent with the requirements of federal and state law, UAMS will not provide access to or disclose PHI without the patient’s Authorization. In addition, UAMS will verify the identity of a person requesting PHI and the authority of the person to have access to PHI, if the identity or authority of the person is not known to the personnel receiving the request for such information.

**NOTE: Patient Directory.** If a person is asking for the information in the UAMS Patient Directory, the person only needs to identify the patient by name, and UAMS may release the location of the patient in our facility, and the patient’s general condition described in a one-word statement, such as good, fair, serious or critical, unless the patient has asked us not to. Please refer to UAMS Patient Directory Policy, 3.1.20.

**A. Requirements of Authorization:** For an authorization from a patient or the patient’s Legal Representative to be valid, it must be written in plain language, and contain the following elements:

1. A specific description of the information to be used or disclosed.
2. The persons, or class of persons, authorized to make the requested use or disclosure.
3. The name (or other specific identification) of the persons, or class of persons, to whom UAMS may disclose the records.
4. A description of each purpose of the requested use or disclosure.
5. An expiration date or expiration event.
6. A statement that the person can revoke the authorization in writing, the process for revoking the authorization, and a statement that the person cannot revoke authorization for records already released in reliance upon the authorization.
7. A statement that UAMS will not condition treatment or payment on the whether the individual signs the authorization, unless the authorization is for research purposes, and then UAMS may condition research-related treatment upon the signing of the authorization.
8. A statement that records or information in the records released might be redisclosed by the person receiving them and will not be covered under the federal privacy laws.
9. Signature of the patient and date; and
10. If the authorization is signed by a Legal Representative of the patient, a description of the Representative’s authority to act for the patient, (e.g., “parent of a minor,” “Court-appointed guardian,” “health care proxy,” “pursuant to appointment under Power of Attorney.”)

**B. UAMS Authorization Forms:** The following forms are available and attached to this Policy:

1. UAMS Authorization for Release of Information From UAMS
2. UAMS Authorization for Release of Information To UAMS
3. UAMS Authorization for Release of Psychotherapy Notes
4. UAMS Substance Abuse Clinic Authorization for Release of Confidential Information
5. UAMS Office of Communications HIPAA Authorization to Allow Access to Patients
C. **Authorizations Requested by UAMS:** If UAMS requests a written authorization from the patient to release records, the authorization must contain those items in Paragraph A above.

D. **Combining Authorizations:** The authorization may not be combined with any other document except as follows:

1. A patient authorization for use and disclosures created for a research study may be combined with any other type of written permission for the same research study; or

2. A patient authorization for a use or disclosure of Psychotherapy Notes may only be combined with another authorization for a use or disclosure of Psychotherapy Notes.

E. **Conditioning:** UAMS will not condition provision of treatment or payment on obtaining patient authorization to use or disclose PHI except under the following circumstances:

1. Research related treatment; or

2. Provision of health care solely for the purpose of creating PHI for disclosure to a third party, for example pre-employment physicals.

F. **Continuing Effect of Authorization:** A valid authorization shall be effective for the release of PHI for 90 days from the date it is signed unless the authorization specifies a different period of time, or the patient or patient’s Legal Representative later revokes the authorization.

G. **Patient’s Revocation of Authorization:** The patient has the right to revoke/cancel his or her Authorization previously given to UAMS. The revocation must be in writing, signed by the patient, and delivered to the Medical Records Department of the appropriate UAMS clinic or to the UAMS Health Information Management office. The revocation will not apply to records already released in reliance upon the Authorization.

H. **Photocopies of Authorization:** A photographic copy or facsimile of a signed authorization may be accepted, as long as the authorization otherwise meets the requirements of this Policy.

I. **Provide Copy of Authorization to Patient/Patient’s Representative:** When patient or patient’s Legal Representative signs an Authorization for Release of Information Form, a copy of the signed form must be provided to the person signing the form.

J. **Authorization for Release of Decedent’s Records:** An Authorization to release PHI of a deceased person can be signed by the following:

1. The parent of a deceased minor; or

2. A person appointed by a court to act on behalf of the estate of the deceased, such as an Executor or Administrator. If the Authorization is signed by a person stating he or she has been appointed by a court to act on behalf of the estate of the deceased, a copy of the court order is required; or

3. Other persons authorized by law to act on behalf of the deceased individual or the estate of the deceased individual.
K. **Authorization for Unemancipated Minor:** Generally, an authorization for release of PHI concerning a minor (under 18 years of age) who is unemancipated (living at home, and dependent on parents for financial support, education, medical care, etc.) can only be given by a parent or legal guardian of the patient.

L. **Authorization of Unemancipated Minor of Divorced or Separated Parents:** If the parents are divorced or legally separated, either parent (who has not had his/her parental rights terminated by the court) may sign the authorization unless a valid court order specifies otherwise.

M. **Authorization of Emancipated Minor:** An authorization for release of PHI concerning a minor (under 18 years of age) who is emancipated (not living at home and not dependent on parents for support, medical care, education, etc.) can only be given by the patient himself.

N. **Authorization by One Standing in Loco Parentis:** An authorization for release of PHI concerning a minor (under 18 years of age) who is unemancipated may be given by an adult who stands “in loco parentis” to the minor. (A person standing “in loco parentis” is one who is responsible for providing all support for the minor.)

O. **Keep Authorization in Record:** The original or a copy of every authorization to release PHI will be maintained as a permanent part of the medical record.

P. **Refusal to Honor Authorization:** UAMS may refuse to honor an authorization in the following situations:
   1. When there is a question as to the identity or authority of the person requesting release of the records;
   2. When there is a doubt that the person requesting the information is the person named in the authorization;
   3. If UAMS has knowledge that the person who signed is not of legal age or is incompetent;
   4. When there is a question as to the legal guardian of a minor or incompetent patient;
   5. When there is a reason to know the patient may not want the authorization honored;
   6. When there is any question as to the authenticity of the signature of the patient or person signing on behalf of the patient;
   7. When the requirements of this policy have not been met; or
   8. If there is a reasonable belief that a minor patient has been abused or neglected and that releasing the record to the personal representative requesting it might endanger the child.

SECTION 8 - DISCLOSURE OF INFORMATION OUTSIDE UAMS FOR PURPOSES UNRELATED TO TREATMENT, PAYMENT AND OPERATIONS

A. **General Rule Concerning Disclosure Outside UAMS:** UAMS may not release PHI externally unless it is in accordance with UAMS policies and consistent with federal, state and local laws, rules and regulations.

B. **Verification:** UAMS will verify the identity and authority of the person requesting PHI.

**Disclosure of Information to Attorneys:** PHI shall not be released to any attorney (including an attorney of the patient) unless the request is accompanied by a proper Authorization from the patient (or patient’s Legal Representative authorized by law to act on behalf of the patient concerning health care matters), and the authorization must contain the required elements of an Authorization stated above. The request must meet all other applicable requirements of this policy. If the attorney is requesting the records for a family member or any other person claiming to have the authority to act on behalf of the patient, the authority of the person to act on behalf of the patient must be verified in accordance with this Policy.

**Disclosure of Information to the News Media:** All requests for releases of PHI to the news media should be referred to the UAMS Office of Communications and Marketing.
E. **Disclosure of Information to Patient’s Employer:** PHI shall not be released directly to a patient’s employer unless the request is accompanied by a proper Authorization from the patient, and the request meets the applicable requirements of this Policy. If you are providing PHI directly to the patient for the patient to provide to an employer, then the Authorization Form is not required.

F. **Disclosure of Information to Schools:** PHI shall not be released to school personnel, teachers, or school nurses unless the request is accompanied by a proper Authorization as required by this Policy, and the request meets the applicable requirements of this Policy. If you are providing PHI directly to the patient for the patient to provide to a school, then the Authorization Form is not required.

G. **Disclosure of Psychotherapy Notes:** Psychotherapy notes are separate from and are not a part of a patient’s medical record or contained in a Designated Record Set. The use and disclosure of psychotherapy notes is very limited. Psychotherapy notes may be used only by the originator of the notes to carry out treatment, or by UAMS for its own training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills in group, joint, family or individual counseling; or for UAMS to defend itself in a legal action or other proceeding brought by the patient, or by health learn under supervision to practice or improve their skills in counseling, or by UAMS as required by law. All other uses or disclosures of psychotherapy notes require the patient’s authorization using a separate authorization form. An example of an Authorization for Release of Psychotherapy Notes is attached to this Policy. See definition of “Psychotherapy Notes” stated in this Policy and refer to UAMS Psychotherapy Notes Policy, 3.1.24 for additional information.

H. **Adoption Records:** Adoption information and records shall be confidential and shall not be released without a court order authorizing release to a specific person. Any questions pertaining to release of adoption records should be referred to Office of General Counsel.

SECTION 9 – REQUIRED BY LAW – No Patient Authorization Required.

UAMS may use or disclose PHI to the extent required by law, with the condition that:

(a) the PHI used or disclosed is limited to the relevant requirements of such law; and (b) the disclosure is made only to the authorities authorized to receive the information.

“Required by law” generally means a requirement in the law that compels an entity to make a use or disclosure of information that is enforceable in a court of law. For example, some state and federal statutes or regulations require hospitals to report certain health information to the Arkansas Department of Health, the Arkansas Department of Human Services, the Arkansas State Medical Board, the Arkansas State Board of Nursing, or the Arkansas Pharmacy Board.

The following list of reporting requirements stated below is not intended to be all inclusive, but merely to show examples.


B. **Deaths from Suspicious Circumstances, Criminal Conduct or Other:** UAMS must notify the county coroner and the chief law enforcement official of the county and town/city in which a death occurred if UAMS has knowledge of the death, and UAMS suspects that the death occurred as a result of violence, criminal conduct or of any of the other circumstances listed in Ark. Code Ann. § 12-12-315. Also see Section 13 of this Policy for partial list.
C. **Disease and Disease Prevention:** Arkansas Department of Health must receive reports of a positive test at UAMS for the presence of conditions or diseases identified by statute such as the reporting of sickle cell anemia, and any case or suspected case of Reye’s Syndrome. Immunizations given to persons under 22 years old must be reported to the Arkansas Department of Health. Ark. Code Ann. §§ 20-15-302, 20-15-401, 20-15-1203.

D. **Sudden Infant Death Syndrome:** The County Coroner must receive reports of the sudden death of a child between the ages of one (1) week and one (1) year who appeared in apparent good health, as required by Ark. Code Ann. § 20-15-502. If the County Coroner is unavailable, the report is made to the County Sheriff. The County Coroner or County Sheriff reports the death to the Arkansas Department of Health.

E. **Child Maltreatment/Abuse/Neglect:** The DHS Arkansas Child Abuse Hotline must receive reports if any health care professional or medical personnel at UAMS has reasonable cause to suspect that a child under 18 years of age has been subjected to maltreatment, abuse, neglect, sexual exploitation or abandonment; and the Arkansas Department of Human Services and Law Enforcement Officials shall have access to medical records, photographs or videotapes relating to the existence or extent of the maltreatment, abuse or neglect. Ark. Code Ann. § 12-12-506 through § 12-12-508.

F. **Abuse of Elderly, Endangered or Impaired Adult:** The Arkansas Department of Human Services (including the Office of Long Term Care), the Office of Attorney General, the County Prosecutor, the County Coroner, and the Adult Abuse Hotline are entitled to receive information if any health care professional or employee of UAMS has reasonable cause to suspect the abuse or neglect of an endangered or impaired adult or an adult residing in a long-term care facility and shall have access to the medical records or other information requested in connection with the investigation of suspected abuse or neglect. Ark. Code Ann. § 5-28-203, § 5-28-204, and § 5-28-209.

G. **Intentional Infliction of Knife or Gunshot Wounds:** The Office of the County Sheriff and the City Police are entitled to receive information in connection with all cases of knife or gunshot wounds treated by UAMS or while in UAMS, if the wounds appear to have been intentionally inflicted. Ark. Code Ann. § 12-12-602.

H. **Venereal Disease:** The Division of Health Maintenance of the Arkansas Department of Health must be notified when a laboratory examination determines that a specimen from a human body yields microscopical, cultural, serological, or other evidence suggestive of a venereal disease. Ark. Code Ann. § 20-16-501.

I. **HIV:** The Arkansas Department of Health must receive reports of any person determined to have AIDS or to have tested positive for HIV. Ark. Code Ann. § 20-15-905 and 20-15-906.

J. **U.S. Department of Health and Human Services:** UAMS must disclose PHI to the Secretary of the U.S. Department of Health and Human Services for purposes of investigating or determining UAMS’ compliance with HIPAA regulations.


The identity and authority of the person to whom the patient’s PHI is being disclosed must be verified, if not known, prior to the disclosure.

NOTE: For all such disclosures under this Section, see UAMS *Accounting for Disclosures Policy, 3.1.26.*

**SECTION 10 – REPORTING TO AGENCIES or OTHERS AUTHORIZED BY LAW TO RECEIVE THE INFORMATION – No Patient Authorization Required, But Certain Limitations.**

UAMS may use or disclose PHI, without patient authorization, when required or allowed to do so by law for the purpose of reporting to governmental agencies or other authorized individuals, with the condition that (a) the PHI
disclosed is limited to the relevant requirements of such law; (b) the disclosure is made only to the authorities authorized to receive the information; and (c) the PHI disclosed is limited to the minimum necessary required for the intended use or purpose of the information. The release of PHI under these circumstances does not change the requirement to protect and maintain the confidentiality of the patient’s PHI.

The identity and authority of the person to whom the patient’s PHI is being disclosed must be verified. UAMS Verification of Identity Policy, 3.1.37.

A. Public Health Authorities: UAMS may disclose PHI to public health authorities authorized by law to receive such information when the disclosure is made in connection with a public health concern, such as for the purpose of preventing or controlling disease, injury, or disability, for the purpose of reporting to the FDA, or to notify persons who may have been exposed to a communicable disease if authorized under state law to do so.

B. Health Oversight Agencies: Health oversight agencies are agencies of the state or federal government, or entities acting under a grant of authority or contract with the public agency, which are authorized by law to oversee the health care system or government programs in which health information is necessary to determine eligibility or compliance. UAMS may disclose PHI to health oversight agencies for health oversight purposes authorized by law, including audits, investigations, inspections, licensure or disciplinary actions, and other activities necessary for appropriate oversight of the health care system. For example, Medicare and Medicaid, State licensure boards, DHHS Office of Inspector General, and DHHS Office for Human Research Protections or other agencies authorized by law to oversee the health care system.

C. Coroners and Medical Examiners: UAMS may disclose PHI to coroners and medical examiners for the purpose of identifying a deceased person, for determining a cause of death, or for coroner or medical examiner to perform other duties authorized by law.

D. Funeral Directors: UAMS may disclose PHI as needed for the funeral director to carry out their duties. UAMS may share PHI prior to, and in reasonable anticipation of, the patient’s death.

E. Organ/Eye/Tissue Donation Organizations: UAMS may use or disclose PHI to an organ procurement organization or entity engaged in the procurement, banking, or transplantation of cadaveric organs, eyes, or tissue for the purpose of facilitating organ, eye or tissue donation and transplantation.

F. Workers’ Compensation: UAMS may disclose PHI to comply with the laws relating to workers’ compensation or other similar programs that provide benefits for work-related injuries or illness without regard to fault.

NOTE: For all such disclosures under this Section, see UAMS Accounting for Disclosures Policy, 3.1.26.

SECTION 11 - COURT ORDERS, WARRANTS AND GRAND JURY SUBPOENAS – No Patient Authorization Required.

UAMS may disclose PHI, without patient authorization, as directed by the following:

1. a court order;
2. a court-ordered warrant; or
3. a grand jury subpoena.

The PHI disclosed must be limited to the PHI described in and required by the order, warrant or grand jury subpoena.

In addition, the PHI must be disclosed only to those persons identified in the order, warrant or grand jury subpoena as http://uams.edu/AdminGuide/Win03128.html

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persons directed to receive the information.

NOTE: For all such disclosures under this Section, see UAMS Accounting for Disclosures Policy, 3.1.26.

SECTION 12 – SUBPOENAS and DISCOVERY REQUESTS FROM PARTIES IN LITIGATION – Patient Authorization, Court Order, or Written Assurances Required.

A. General. This Section covers subpoenas and discovery requests from parties in litigation: This Section does not cover subpoenas from a Grand Jury or from Law Enforcement. UAMS may disclose PHI in response to a valid subpoena or in response to a discovery request by parties in litigation only if UAMS also receives any one of the following:

1. An Authorization signed by the patient or patient’s Legal Representative.
   a. The Authorization must authorize release of the records described in the subpoena or include a description broad enough to encompass the records described in the subpoena.
   b. The Authorization must authorize release of the records to the person or persons identified in the subpoena.
   c. The Authorization must be a HIPAA compliant Authorization containing the elements described in this Policy.
   d. A patient’s attorney is not the patient’s “Legal Representative” for purposes of signing an Authorization. If the Authorization is not signed by the patient, it must be signed by the patient’s “Legal Representative” who is a person authorized by law to act on behalf of the patient. For example, a court-appointed guardian, a person designated as the patient’s attorney-in-fact in a power of attorney, or the parent of an unemancipated minor.

2. A court order, or an order of an administrative tribunal such as the Workers’ Compensation Commission.

3. Written assurances that patient was notified of the subpoena for the patient’s records, and the patient does not object to the production of the records, or the patient’s objections were overruled by the court. To provide such written assurances, the party seeking the patient’s records by subpoena must submit a written statement and documentation to UAMS showing that:
   a. reasonable efforts have been made by such party to ensure that the patient has been notified of the subpoena for the patient’s records;
   b. the notice to the patient included sufficient information about the litigation or proceeding to permit the patient or patient’s attorney to file objections with the court or administrative tribunal;
   c. the time for filing objections has elapsed; and
   d. no objections were filed, or if objections were filed, the court or administrative tribunal ordered the disclosure, and a copy of the order should be provided.

These written assurances may occur in stages. For example, UAMS may first receive the subpoena, along with documentation showing that a copy of the subpoena was provided to the patient or the patient’s attorney. After the time for filing objections has passed, UAMS may later receive the written assurance that the time for filing objections has passed and the patient did not object.

B. Subpoena Without Authorization, Court Order, or Written Assurances: If a subpoena for patient’s PHI does not include any other authority for releasing the records, such as the patient’s Authorization, a court order,
or the written assurances described above, UAMS is not authorized to release the records. UAMS should undertake reasonable efforts to inform the party seeking the records, prior to the date of production stated in the subpoena if possible, that

UAMS is not authorized to release the records without the required Authorization, court order, or written assurances.

NOTE: If no signed patient Authorization (HIPAA-compliant) and for all such disclosures under this Section, see UAMS Accounting for Disclosures Policy, 3.1.26.

SECTION 13 – SUBPOENAS FROM LAW ENFORCEMENT OFFICIALS.

No Patient Authorization Required, But Certain Limitations.

A. General: UAMS may disclose PHI to law enforcement officials in response to a valid subpoena, Investigative Demand (which is usually headed “Investigative Demand”), or similar process authorized by law, as long as:

(a) The information requested is relevant and material to a legitimate law enforcement inquiry;
(b) The request is specific and limited in scope to the extent reasonably practicable in light of the purpose from which the information is sought; and
(c) de-identified information could not reasonably be used.

B. Law Enforcement Official: Law Enforcement Official means an officer or employee of any agency or authority of the United States, a State, a territory, a political subdivision of a State or territory, or an Indian tribe, who is empowered by law to: (1) Investigate or conduct an official inquiry into a potential violation of law; or (2) Prosecute or otherwise conduct a criminal, civil, or administrative proceeding arising from an alleged violation of law.

This would include subpoenas from the Arkansas Office of Attorney General, the Prosecuting Attorney’s Office, the FBI, and the police.

NOTE: For all such disclosures under this Section, see UAMS Accounting for Disclosures Policy, 3.1.26.

SECTION 14 – LAW ENFORCEMENT GENERALLY (Without Court Order or Warrant, Subpoena, or Other Legal Process) – No Patient Authorization Required, But Certain Limitations.

A. Disclosures for Identification and Location of Suspect, Fugitive, Material Witness or Missing Person:

1. PHI Allowed to be Disclosed: In response to law enforcement’s request or notice for information to identify or locate a suspect, fugitive, material witness or missing person, UAMS may disclose the following information only:

   a. name and address;
   b. date and place of birth;
   c. Social Security Number;
   d. ABO blood type and rh factor;
   e. type of injury;
   f. date and time of treatment;
   g. date and time of death, if applicable; and
   h. description of distinguishing physical characteristics, such as weight, height, gender, race,
2. **Disclosure Not Allowed:** UAMS may not disclose the following information in response to law enforcement’s request or notice for information to identify or locate a suspect, fugitive, material witness or missing person:
   a. DNA or DNA analysis;
   b. dental records;
   c. typing, samples or analysis of body fluids or tissue.

**B. To Prevent or Lessen Serious and Imminent Threat to Health or Safety:**

1. **Disclosures to Law Enforcement:** UAMS may, consistent with the law and standards of ethical conduct, use or disclose PHI to a Law Enforcement Official, without patient authorization or other authority, if UAMS believes in good faith that the use or disclosure is:
   a. necessary to prevent or lessen a serious and imminent threat to the health or safety of any person or the public;
   b. and the disclosure is (i) to persons reasonably able to prevent or lessen the threat, such as law enforcement; or (ii) the disclosure is necessary for law enforcement to identify or apprehend an individual because of a statement made by an individual admitting participation in a violent crime that the covered entity reasonably believes may have caused serious physical harm to the victim or where it appears from the circumstances that the individual has escaped from a correctional institution or from lawful custody.

2. **Disclosures to Others:** UAMS may, consistent with the law and standards of ethical conduct, use or disclose PHI, without patient authorization or other authority, if UAMS believes in good faith that the use or disclosure is:
   a. necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public;
   b. and the disclosure is (i) to persons reasonably able to prevent or lessen the threat, including the target of the threat; or (ii) the disclosure is necessary for law enforcement to identify or apprehend an individual because of a statement made by an individual admitting participation in a violent crime that the covered entity reasonably believes may have caused serious physical harm to the victim or where it appears from the circumstances that the individual has escaped from a correctional institution or from lawful custody.

**C. To Report a Crime on UAMS Property:** UAMS may disclose PHI to a Law Enforcement Official if UAMS believes in good faith that the PHI disclosed constitutes evidence of criminal conduct that occurred on the premises of UAMS.

**D. Deaths:** UAMS must notify the county coroner, the chief law enforcement official of the county, and the chief law enforcement official of the town/city where the death occurred if UAMS has knowledge of the death and any of the following circumstances appear to exist:

1. death was caused by violence, homicide, suicide or appears to be accidental;
2. death resulted from presence of drugs or poisons in the body;
3. death resulted from drowning;
4. death resulted from motor vehicle accident or body was found in or near a roadway or railroad;

5. death occurred in hospital and no previous medical history to explain the death;

6. death occurred while person in policy custody, a jail, or penal institution;

7. death resulted from fire or explosion;

8. death of minor indicated child abuse prior to death;

9. death of minor and no prior medical history to explain the death;

10. human skeletal remains were recovered or unidentified deceased person was discovered;

11. death was due to criminal abortion;

12. manner of death was from other than natural causes;

13. death was sudden and unexplained;

14. death occurred at work site; or

15. death occurred in the home.

See Arkansas Code Ann. 12-12-315 for additional examples.

E. Suspected Child Abuse or Neglect: If there is reasonable cause to suspect that a child has been subjected to abuse/neglect or has died as a result of abuse/neglect, or if a child is observed being subjected to conditions or circumstances that would reasonably result in child abuse/neglect, UAMS must use and disclose PHI for purposes of contacting the Arkansas Child Abuse Hotline and reporting to the authorities authorized by law to receive such information, such as the Arkansas Department of Human Services and other Law Enforcement Officials investigating the suspected abuse/neglect.

F. Abuse of Elderly, Endangered or Impaired Adult: UAMS must use and disclose PHI to the Arkansas Department of Human Services (including the Office of Long Term Care), the Office of Attorney General, the County Prosecutor, the County Coroner, or the Adult Abuse Hotline if UAMS has reasonable cause to suspect the abuse or neglect of an endangered or impaired adult or an adult residing in a long-term care facility and these agencies may have access to the medical records or other information requested in connection with the investigation of suspected abuse or neglect.

1. Informing the victim is required: If UAMS makes a disclosure in the case of abuse of elderly, endangered or impaired adults, UAMS must promptly inform the patient/victim that such a report has been or will be made. See exceptions below.

2. You do not have to inform the victim in certain limited circumstances: Informing the patient/victim that UAMS has or will report the suspected abuse/domestic violence is not required if: (1) UAMS believes, in the exercise of professional judgment, that informing the individual would place the individual at risk of serious harm; or (2) UAMS would be informing a Legal Representative of the
patient who is authorized by law to act on behalf of the patient (such as a court-appointed guardian), and UAMS reasonably believes the Legal Representative is responsible for the abuse, neglect, or other injury, and that informing such person would not be in the best interests of the patient/victim.

G. **Other Law Enforcement Purposes:** PHI also may be used and disclosed without patient authorization or permission in the following circumstances:

1. For specialized government activities including military and veterans’ activities, national security and intelligence activities and protective services for the President and others.

2. To correctional institutions and law enforcement officials about an individual who is an inmate or is in their lawful custody if necessary for the health and safety of the individual, other inmates, officers or other employees at the correctional institution, or persons responsible for the inmate’s transportation or otherwise for the administration and maintenance of the safety, security and good order of the correctional institution

3. If emergency medical care is provided, other than on the premises of UAMS, and disclosure of PHI appears necessary to alert law enforcement to: (a) the commission and nature of a crime; (b) the location of the crime or the victims of the crime; or (c) the identity, description and location of the perpetrator of the crime.

**NOTE:** For all such disclosures under this Section, see UAMS *Accounting for Disclosures Policy, 3.1.26.*

SECTION 15 – ADULT VICTIMS OF ABUSE, NEGLECT or DOMESTIC VIOLENCE – Reporting to Authorities Requires Patient Consent.

A. **Victim’s Consent Required:** *Except for* the circumstances listed below in “Exceptions,” UAMS must obtain the written or verbal consent of a patient (age 18 or older) whom UAMS reasonably believes to be a victim of abuse or domestic violence *before* UAMS can report the suspected abuse or domestic violence to a government authority authorized by law to receive such reports, such as the police, DHS, a social services agency or a protective services agency. (If the government authority authorized by law to receive such reports presents a subpoena, court order or warrant, then refer to the various Sections in this policy regarding subpoenas, court orders and warrants, whichever is applicable.)

**The consent may be written or verbal:** An Authorization form is not required, but may be used. Once consent is given, the medical evidence relevant to the victim’s injuries and the alleged crime may be disclosed.

B. **Exceptions:** Victim consent is not required for:

1. Reports of abuse/neglect of a child under 18.

2. Reports of abuse/neglect of the elderly or an impaired or endangered adult.

3. Disclosures of certain limited information to Law Enforcement to identify or locate a suspect, fugitive, material witness or missing person. See section of this Policy entitled “Law Enforcement Generally.”

4. All other disclosures required by law and to the extent that the disclosure complies with and is limited to the relevant requirements of such law (such as reporting deaths, intentional infliction of gunshot or knife wounds, and other reporting requirements). See section of this Policy entitled “Law Enforcement Generally” and see “Required by Law” section for disclosures required by law.

5. Disclosures made pursuant to a court order, warrant or other similar legal process enforceable in a court or law.
C. **If Victim Incapacitated:** If UAMS is unable to obtain the victim’s agreement because the victim is incapacitated, UAMS can disclose the victim’s PHI only if all of the elements of “Circumstances ONE” or “Circumstances TWO” exist:

**Circumstances ONE**

1. The disclosure is expressly permitted by statute or regulation; and  
2. The Law Enforcement Official represents that (a) such information is needed to determine whether a violation of law by a person other than the victim has occurred, and (b) such information is not intended to be used against the victim; and  
3. The Law Enforcement Official represents that immediate law enforcement activity that depends upon the disclosure would be materially and adversely affected by waiting until the individual is able to agree to the disclosure.

**OR**

**Circumstances TWO:**

1. The disclosure is expressly permitted by statute or regulation; and  
2. UAMS workforce members involved believe that, in the exercise of professional judgment, the disclosure is necessary to prevent serious harm to the individual or other potential victims.

D. **When Informing the Victim of Disclosure/Report is Required:**

1. **Informing the victim is required:** If UAMS makes a disclosure with the consent of the patient/victim, as described above, or in the case of abuse of elderly, endangered or impaired adults where consent is not required, UAMS must promptly inform the patient/victim that such a report has been or will be made. See exceptions below.

2. **You do not have to inform the victim in certain limited circumstances:** Informing the patient/victim that UAMS has or will report the suspected abuse/domestic violence is not required if: (1) UAMS believes, in the exercise of professional judgment, that informing the individual would place the individual at risk of serious harm; or (2) UAMS would be informing a Legal Representative of the patient who is authorized by law to act on behalf of the patient (such as a court-appointed guardian), and UAMS reasonably believes the Legal Representative is responsible for the abuse, neglect, or other injury, and that informing such person would not be in the best interests of the patient/victim.

NOTE: If no signed patient Authorization (HIPAA-compliant) and for all such disclosures under this Section, see UAMS Accounting for Disclosures Policy, 3.1.26.

**SECTION 16 -- ADULT VICTIMS OF RAPE, ATTEMPTED RAPE, SEXUAL ASSAULT OR INCEST – Reporting to Authorities Requires Patient Consent.**

UAMS will follow the requirements of Arkansas law, Ark. Code Ann. 12-12-401 through 12-12-405 regarding treatment of victims of rape, attempted rape, sexual assault or incest.

If an adult patient, age 18 years or older, is presented for treatment as a victim of rape, attempted rape, any other type of sexual assault, or incest, the adult patient shall make the decision of whether the incident will be reported to a law
enforcement agency. If consent is given to UAMS to contact law enforcement on behalf of the victim, the consent may be given verbally. A HIPAA-compliant authorization is not required, but may be used.

UAMS may not require an adult victim to report the incident in order to receive medical treatment. Evidence will be collected only with the permission of the victim. However, permission to collect such evidence shall not be required in instances where the victim is unconscious, mentally incapable of consent or intoxicated. Once evidence is collected, it will be provided to law enforcement with the permission of the victim.

See UAMS Policy ML.1.08 regarding sexual assault of adult.

NOTE: If no signed patient Authorization (HIPAA-compliant) and for all such disclosures under this Section, see UAMS Accounting for Disclosures Policy, 3.1.26.

SECTION 17 – SUBSTANCE ABUSE/TREATMENT INFORMATION – Patient Authorization Requiring Using Substance Abuse Treatment Form.

A. Patient Authorization Required: For patients of the UAMS Substance Abuse Treatment Center or any other UAMS substance abuse treatment program, the patient’s signed Authorization must be obtained before UAMS can disclose any PHI relating to the diagnosis, prognosis, treatment, or referral for treatment in relation to substance abuse (drug or alcohol), including any information which would identify the person as being a patient in such a program, or acknowledgment or confirmation that the person is or was a patient in such a program.

Access the UAMS Substance Abuse Treatment Authorization form.

B. Exceptions: An authorization signed by the patient is not required in very limited circumstances, such as pursuant to a court order directing the disclosure of information or records specifically relating to substance abuse. Consult the UA Office of General Counsel for further information in response to a request or subpoena for such information in the absence of a court order or patient Authorization.

SECTION 18. MINORS.

A. Release of Minors’ PHI to Minors’ Parents: Generally, the parent of a dependent child under the age of 18 is entitled to all PHI concerning their minor child, regardless of whether the parents are divorced. A divorced parent who does not have custody of the minor child is still the minor’s parent, and is entitled to all PHI concerning their minor child. See exceptions below.

B. Release of Minors’ PHI to Minors’ “Legal Representative:” The “Legal Representative” of a child is one who has legal authority to act on behalf of the child, including the authority to make health care decisions for the child. Examples are (1) the parent; (2) a court-appointed Guardian; (3) a person legally acting as a parent (“in loco parentis” – the person has physical custody and supervision of the child, and the child lives with and is supported by the person); or (4) any other court order providing the person with legal custody or the legal authority to act on behalf of the child.

C. Exceptions to Providing PHI to Parent or Legal Representative of Minor Child: UAMS is not required to provide a person who has authority to act on behalf of a minor with the PHI of the minor in the following circumstances:

1. Court Order: A court order terminates the parental rights of the parent over the minor child or children. Issues relating to custody do not apply. The court order must specifically terminate the parent’s rights.

2. Not in Best Interest of Child: UAMS has a reasonable belief that the child has been or may be subjected to domestic violence, abuse or neglect by such person, or if UAMS has a reasonable belief that
the person may cause physical or emotional harm to the child, or if UAMS determines in the exercise of professional judgment that it is not in the best interest of the child to release the information.

3. **Biological Father of Child Born Out of Wedlock:** The request for information is by the biological father of a child born out of wedlock, who does not have physical custody of the child, and who is not married to the mother at the time of the request. The biological father must provide a copy of a court order providing the father with legal custody, parental rights or some other authority to act on behalf of the child or to receive information.

4. **Venereal Disease:** The minor has consented to their own treatment for a known or suspected venereal disease. However, the treating physician may release the information to the minors’ parents or Legal Representatives if the treating physician determines that the information should be released, even over the objections of the minor. This does not prohibit the confidential reporting of a confirmed case of a venereal disease to the Arkansas Department of Health as required under Arkansas law. All records of such information concerning the minor’s known or suspected venereal disease should be maintained in a manner that the user can determine immediately and easily that the records are confidential and are not to be released with the rest of the medical record.

**SECTION 19. EMERGENCY CIRCUMSTANCES – No Patient Authorization Required.**

**NOTE:** For purposes of this Section, when “good faith” is required, “good faith” is presumed to exist if it is based upon the actual knowledge of UAMS or is based upon UAMS’ reliance on a credible representation by a person with apparent knowledge or authority.

A. **To Prevent or Lessen Serious and Imminent Threat to Health or Safety:** UAMS may, consistent with the law and standards of ethical conduct, use or disclose PHI if UAMS believes in good faith that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of any person or the public in general; and the disclosure is to persons reasonably able to prevent or lessen the threat, such as to law enforcement or to the target of the threat or to others reasonably able to prevent or lessen the threat.

B. **Admission by Patient of Participation in Violent Crime:** UAMS may, consistent with the law and standards of ethical conduct, use or disclose certain PHI to law enforcement authorities if UAMS believes in good faith that the use or disclosure is necessary for law enforcement authorities to identify or apprehend an individual because of a statement made by an individual admitting participation in a violent crime that UAMS reasonably believes may have caused serious physical harm to the victim. (See “Exceptions” listed below.)

1. **Limited PHI to be Used/Disclosed:** In such circumstances where there has been an admission by a patient as described above, UAMS may disclose to law enforcement authorities the following information concerning the patient:
   a. name and address;
   b. date and place of birth;
   c. Social Security Number;
   d. ABO blood type and rh factor;
   e. type of injury;
   f. date and time of treatment;
g. date and time of death, if applicable; and

h. description of distinguishing physical characteristics, such as weight, height, gender, race, hair/eye color, presence or absence of facial hair, scars, tattoo.

DNA or DNA analysis, dental records, typing, samples or analysis of body fluids or tissue, or any other PHI may not be disclosed without a court order or warrant or other legal process.

2. **Exceptions -- Use/Disclosure Prohibited:** Such a use or disclosure may not be made if the admission of the patient is learned by UAMS (1) in the course of treatment to affect the propensity to commit the criminal conduct that is the basis for the disclosure, (2) in counseling of therapy of the patient; or (3) through a request by the patient to initiate or to be referred for the treatment, counseling, or therapy to affect the propensity to commit the criminal conduct that is the basis for the disclosure.

C. **To Identify or Apprehend Escaped Prisoner:** UAMS may, consistent with the law and standards of ethical conduct, use or disclose PHI to law enforcement authorities if UAMS believes in good faith that the use or disclosure is necessary for law enforcement authorities to identify or apprehend an individual where it appears from the circumstances that the individual has escaped from a correctional institution or from lawful custody.

D. **Medical Emergencies:** UAMS may disclose PHI to a person who is the spouse, family or friend involved in the patient’s care, without patient’s consent or Authorization, in the event of a medical emergency.

**SECTION 20 – PATIENT REQUEST TO AMEND RECORD.**

A patient has the right to request UAMS to amend his or her PHI maintained in the Designated Record Set. UAMS is not required to agree to all requests by patients to amend their records. Requests to amend will be referred to the Release of Information Office in Health Information Management/Medical Records Department and processed in accordance with the UAMS [Patient Request to Amend the Medical Record Policy, 3.1.32](http://uams.edu/AdminGuide/Win03128.html).

**SECTION 21- COSTS OF OBTAINING COPIES OF MEDICAL RECORDS.**

UAMS may charge a reasonable, cost-based fee for copies of medical records that includes the cost of copying, cost of supplies and labor of copying, and postage, when the patient has requested the copy be mailed. UAMS will not charge more than is allowed by law and pursuant to Ark. Code Ann. § 16-46-106.

**SECTION 22 – SANCTIONS/DISCIPLINARY ACTION.**

UAMS workforce who engage in activity in violation of this Policy may be subject to disciplinary action, up to and including termination of employment or relationship with UAMS.
Authorization for Release of Information from UAMS

1. I, ____________________________, hereby authorize UAMS to release to:

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone</th>
<th>Fax</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Address</th>
<th>Street Address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
</table>

2. Information of:

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Medical Record No. (if known)</th>
<th>Date of Birth and/or Social Security No.</th>
<th>Phone</th>
</tr>
</thead>
</table>

3. Information is to be limited to the following Dates of Treatment (if applicable):

4. Information requested to be accessed or released:

- _____ Abstract
- _____ Operative Report
- _____ ER Record
- _____ History & Physical
- _____ Discharge Summary
- _____ Clinic Record
- _____ Admission Record
- _____ Physicians’ Progress Notes
- _____ Nurses’ Progress Notes
- _____ Other

_____ Records of Other Providers on File With UAMS (if any) (We must impose our standard copying fees as stated below. UAMS does not represent that these records are the complete records of the other providers. If you want a complete copy of the records created by the other providers for this patient, you may wish to contact each provider.)

I understand that if the records requested to be released include information relating to sexually transmitted disease, AIDS or HIV, alcohol or drug abuse, or mental health information, this information may be released pursuant to this authorization.

5. _____ Billing Records. For hospital billing records, please contact Patient Business Services (PBS) at (501) 614-2888.
   For physician billing records, please contact Medical College Physician’s Group (MCPG) at (501) 614-2160, or 1-800-559-6274.

6. Purpose of access or release: _____ Medical Care _____ Insurance or Other Payment _____ At Request of the Patient
   _____ Other (explain): ____________________________

7. This authorization will expire 90 days from the date on which it was signed unless I specify a different time period. Expiration Date or Event: _____________________________. I understand that I may revoke this authorization at any time by giving written notice to UAMS. A revocation of this authorization will not apply to records already released in reliance upon the authorization. A photocopy of this signed authorization shall constitute a valid authorization.

8. UAMS, its employees and attending physicians are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

9. I understand that once the above information is disclosed, it may be re-disclosed by the designated recipient and the information may no longer be protected by Federal privacy laws and regulations.

10. I agree to pay the copying cost, including other expenses allowed by law, such as the cost of any supplies, labor of copying, postage, or other expenses incurred by UAMS to provide the copies requested.

11. UAMS will not condition treatment, payment, enrollment or eligibility for benefits on your signing of this authorization.

Signature of Patient or Legal Representative: ____________________________ Date: __________

If Legal Representative, authority of Legal Representative: ____________________________
(such as parent of a minor, court-appointed guardian, administrator of estate of deceased, attorney-in-fact appointed with power of attorney, or health care proxy)

http://uams.edu/AdminGuide/Win03128.html

11/3/2005
Authorization for Release of Information TO UAMS

1. I, ____________________________________________, hereby authorize:

Name/Facility ____________________________________________

Address

<table>
<thead>
<tr>
<th>Street Address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fax</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. To release to: UAMS Medical Center
    Dr./Clinic ____________________________
    4301 West Markham, Mail # _____________
    Little Rock, AR 72205
    Phone (501) ___________________________
    Fax (501) _____________________________

3. Information of:

Patient Name: ____________________________________________

Medical Record No. (if known) ____________________________

Date of Birth and/or Social Security No. ____________________

Phone: ____________________________

4. Information is to be limited to the following Dates of Treatment (if applicable): ____________________________

5. Information requested to be released:

_____ Abstract   _____ Operative Report   _____ ER Record   _____ History & Physical   _____ Discharge Summary

_____ Clinic Record   _____ Admission Record   _____ Physicians’ Progress Notes   _____ Nurses’ Progress Notes   _____

Other

6. Purpose of release: ____ Medical Care   ____ Insurance or Other Payment   ____ At the Request of the Patient

____ Other (explain): ____________________________

7. This authorization will expire 90 days from the date on which it was signed unless I specify a different time period. Expiration Date or Event: _____________________________. I understand that I may revoke this authorization at any time by giving written notice. A revocation of this authorization will not apply to records already released in reliance upon the authorization. A photocopy of this signed authorization shall constitute a valid authorization.

8. I understand that once the above information is disclosed, it may be re-disclosed by the designated recipient and the information may no longer be protected by Federal privacy laws and regulations.

9. Treatment, payment, enrollment or eligibility for benefits will not be conditioned on your signing this authorization.

Signature of Patient or Legal Representative ____________________________ Date: _______

If Legal Representative, authority of Legal Representative

(such as parent of a minor, court-appointed guardian, administrator of estate of deceased, attorney-in-fact appointed with power of attorney, or health care proxy)

EPF Barcode

HIPAA

Med Rec 99 TO (G-3/04)

Provide Copy To Patient/Legal Representative

http://uams.edu/AdminGuide/Win03128.html

11/3/2005
Authorization for Release of Psychotherapy Notes

I, _____________________________________________, hereby authorize UAMS to release to:

Name __________________________________________ Phone: ____________________________

Address: __________________________________________________________________________

Information of: ___________________________________________ Medical Record No. (if known) ________________

Date of Birth and/or Social Security No. ______________________ Phone: ____________________________

Information is to be limited to the following Dates of Treatment (if applicable): __________________________

Information requested to be released: _______ Psychotherapy Notes Only.

I stand that if the records requested to be released include information relating to sexually transmitted disease, AIDS or HIV, alcohol or drug mental health information, this information may be released pursuant to this authorization.

Purpose of access or release: _____ Medical Care _____ Insurance or Other Payment _____ At Request of the Patient

_____ Other (explain): __________________________________________________________________________

This authorization will expire on the following date: _________________. If no date is specified, this authorization shall expire one (1) year from the date signed below. I understand that I may revoke this authorization at any time by giving written notice to UAMS except that a revocation of this authorization will not apply to records already released in reliance upon the authorization. A photocopy of this signed authorization shall constitute a valid authorization.

UAMS, its employees and attending physicians are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

I understand that once the above information is disclosed, it may be re-disclosed by the designated recipient and the information may no longer be protected by Federal privacy laws and regulations.
I agree to pay the copying cost, including other expenses allowed by law, such as the cost of any supplies, labor of copying, postage, or other expenses incurred by UAMS to provide the copies requested.

UAMS will not condition treatment, payment, enrollment or eligibility for benefits on your signing of this authorization.

Name ____________________________________________ Date: ______

al Representative, authority of Legal Representative ______________________________________________________________

(such as parent of a minor, court-appointed guardian, administrator of estate of deceased, attorney-in-fact appointed with power of attorney, or health care proxy)

__________________________
Name ____________________________ Signature: ____________________________

 HIPAA PROVIDE COPY TO PATIENT/LEGAL REPRESENTATIVE

http://uams.edu/AdminGuide/Win03128.html
AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Patient ID#: ______________________

Patient Information:

Patient Name: ______________________ DOB or SSN: ______________________

Send Information To:

Name: ______________________ Phone: ______________________

Address: ______________________ City/State: ______________________ Zip Code: ______________________

Information Requested (check one):

_______ Patient medical record of UAMS Substance Abuse Treatment Clinic; or
_______ Portions of medical record as follows: ______________________

(If only portions of record requested, specifically describe portions of record to be released)

Purpose: ______________________ (describe purpose of release of information as specifically as possible)

I understand that my alcohol and drug treatment records are protected by federal law, Confidentiality and Drug Abuse Patient Records, 42 Code of Federal Regulations Part 2, and Health Insurance Portability and Accountability Act (“HIPAA”), 45 C.F.R. Parts 160 & 164, and cannot be disclosed without my written permission, unless otherwise allowed by law.

I understand that UAMS Substance Abuse Treatment Clinic may not condition my treatment or eligibility for benefits on whether I sign an authorization to release my medical information.

I understand that I may, at any time, revoke this authorization by notifying UAMS Substance Abuse Treatment Clinic in writing, except to the extent that records/information have been released in reliance upon this authorization. If not previously revoked, this authorization expires automatically 30 days after patient is discharged from UAMS - SATC or upon the following date: ______________________.

I hereby authorize the UAMS Substance Abuse Treatment Clinic to release my alcohol or drug treatment records as stated above.

Date: ______________________ ______________________ Signature of Patient or Legal Representative
If signed by Legal Representative on behalf of patient, state authority of Legal Representative, such as parent, court-appointed guardian, health care proxy, appointed by patient in Power of Attorney document or other:

* 42 CFR Part 2 Statement is to be sent with each release of information: ______ Yes    ______ No

(If NO explain) ________________________________________________________________

Provide Patient With Copy of This Authorization After Patient Signs

17-A-0603
This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.
UAMS OFFICE OF COMMUNICATIONS

HIPAA AUTHORIZATION TO ALLOW ACCESS TO PATIENTS AND TO RELEASE PATIENT INFORMATION

I, _________________________________ hereby authorize UAMS to allow the entities indicated below to have access to me for the purpose of ___ photographs, ___ video recording, and ___ audio recording:

___The UAMS Communications and Marketing Department (501)__________________

MEDIA:

___Television________________________________________________

___Radio____________________________________________________

___Print_____________________________________________________

___Other_____________________________________________________

In addition, I hereby authorize UAMS to release to the above-named party: (if applicable)

_________ my current treatment information

_________ my current medical condition

1. **Purpose of access or release:** At Request of Patient.

2. **Expiration Date** – This Authorization expires ninety (90) days from the date I sign the Authorization, unless I specify otherwise by writing in an earlier or later date:___________________

3. **Revocation of Authorization** – I understand that I am not required to sign this Authorization. If I sign this Authorization, I may revoke the Authorization at any time by giving written notice to the UAMS Office of Communications. A revocation of this Authorization will not apply to records, information, photography, or audio/visual recordings already released in reliance upon the Authorization. A photocopy or faxed copy of this signed Authorization shall constitute a valid authorization.

4. **Release of Liability** – I agree that UAMS, including UAMS employees and attending physicians, are hereby released from legal responsibility or liability for the access provided and the release of the above information to the extent indicated and authorized herein.

5. **Re-Disclosure** – I understand that once the above information is disclosed, it may no longer be protected by privacy laws and regulations if such laws and regulations do not apply to the designated recipient, and it may be re-disclosed by the designated recipient.

6. UAMS will not condition treatment, payment, enrollment or eligibility for benefits on your signing of this Authorization.

If Legal Representative has signed on behalf of Patient, state the authority of Legal Representative to do so:

(such as parent of a minor, court-appointed guardian, attorney-in-fact appointed in a Power of Attorney)

Office Staff: Provide Copy of Signed Authorization to Patient/Legal Representative
SCOPE

UAMS Workforce

PURPOSE

To establish guidelines and restrictions for the use and disclosure of Protected Health Information by UAMS in connection with marketing activities.

DEFINITIONS

For purposes of this policy, the following definitions apply:

**Marketing** means communications about a product or service that encourages recipients of the communication to purchase or use the product or service. Marketing also includes any arrangement between UAMS and another party in which UAMS discloses PHI for the other party to make a communication about its own product or service that encourages recipients of the communication to purchase or use that product or service.

For purposes of this policy, “Marketing” does not include the following communications that are made by UAMS:

1. Communications by UAMS to an individual for the purpose of describing to that individual a health-related product or service that is provided by UAMS, or included in a UAMS plan of benefits; or

2. Communications by UAMS to an individual as part of the treatment of the individual; or

3. Communications by UAMS to an individual in the course of managing or coordinating treatment of that individual, or for the purpose of directing or recommending to that individual alternative treatments, therapies, health care providers, or settings of care.

**Protected Health Information (PHI)** means information that is part of an individual’s health information that identifies the individual or there is a reasonable basis to believe the information could be used to identify the individual, including demographic information, and that (i) relates to the past, present or future physical or mental health or condition of the individual; (ii) relates to the provision of health care services to the individual; or (iii) relates to the past, present, or future payment for the provision of health care services to an individual. This includes PHI which is recorded or transmitted in any form or medium (verbally, or in writing, or electronically). PHI excludes health information maintained in educational records covered by the federal Family Educational Rights Privacy Act and health information about UAMS employees maintained by UAMS in its role as an employer.

**UAMS Workforce** means for purposes of this Policy, physicians, employees, volunteers, trainees, and other persons whose conduct, in the performance of work for UAMS, are under the direct control of UAMS, whether
or not they are paid by UAMS.

POLICY

UAMS will not use or disclose a patient’s Protected Health Information (PHI) for Marketing purposes except as allowed by federal and state law, including the Federal HIPAA Privacy Regulations, and any PHI that is used for disclosed by UAMS in compliance with this Policy will be limited to the minimum necessary to achieve the purpose of the use or disclosure.

PROCEDURE

A. **Prior Patient Authorization Required:** Except as allowed by this Policy, UAMS will obtain the patient’s authorization in writing, using a UAMS Authorization form prior to using or disclosing a patient’s Protected Health Information for Marketing purposes. See the UAMS *Use and Disclosure PHI and Medical Records Policy, 3.1.28* for the required elements of a HIPAA compliant authorization. If the Marketing involves direct or indirect remuneration to UAMS from a third party, the Authorization must state that such remuneration is involved.

Patient Authorization also is required prior to the use or disclosure of PHI made in connection with any arrangement between UAMS and another entity whereby UAMS discloses Protected Health Information to the other entity, in exchange for direct or indirect remuneration, for the other entity or its affiliate to make a communication about its own product or service that encourages recipients of the communication to purchase or use that product or service.

This would include, for example, a situation where a company seeks access to a list of UAMS patients or any other PHI which the company will use for its own Marketing activities, regardless of whether the company is to use the PHI on behalf of UAMS as well, and seeks to do so under the guise of a Business Associate relationship or agreement. This situation requires prior patient Authorization.

B. **Prior Patient Authorization NOT Required:** UAMS is not required to obtain a written or verbal Authorization from a patient to use or disclose a patient’s Protected Health Information for any Marketing communications about products or services of UAMS or a third party when the communications occur in the following circumstances:

1. face-to-face communication between UAMS and the patient (this does not include communications by telephone, e-mail or facsimile); or

2. UAMS provides to a patient a promotional gift of nominal value (e.g., items with the UAMS name or another company’s name, or sample products).

C. **Communications Which are NOT Marketing, and Therefore, No Prior Patient Authorization Required:** The following types of communications made by UAMS to an individual are not considered “Marketing” for purposes of this policy, and therefore, no prior patient authorization is required:

http://uams.edu/AdminGuide/Win03136.html

11/3/2005
1. Communications by UAMS to an individual for the purpose of describing to that individual a health-related product or service that is provided by UAMS, or included in a UAMS plan of benefits; or

2. Communications by UAMS to an individual as part of the treatment of the individual; or

3. Communications by UAMS to an individual in the course of managing or coordinating treatment of that individual, or for the purpose of directing or recommending to that individual alternative treatments, therapies, health care providers, or settings of care.

D. Business Associate Agreement Required: If UAMS intends to disclose Protected Health Information to a third party for the purpose of the third party communicating with individuals about the products or services of UAMS, such disclosure does not constitute Marketing communications and does not require patient Authorization. Prior to such disclosure, UAMS is required to enter into a written agreement with the third party, restricting the third party’s use of the Protected Health Information to communications on behalf of UAMS and UAMS’ own products and services. The agreement will be a Business Associate Agreement UAMS Business Associate Policy, 3.1.33 as defined under the HIPAA regulations and approved by UAMS.

Note that the use of a Business Associate Agreement will not take the place of a patient Authorization in situations involving the use or disclosure of PHI to facilitate or conduct communications with patients about the products or services of others. This would include, for example, a situation where a company seeks access to a list of UAMS patients or any other PHI which the company will use for its own Marketing activities to promote its own products or services, regardless of whether the company is to use the PHI on behalf of UAMS as well, and seeks to do so under the guise of a Business Associate relationship or agreement. This situation requires prior patient Authorization.

E. Minimum Necessary: Any and all uses or disclosure of PHI for Marketing purposes in compliance with this Policy will be limited to the minimum necessary to achieve the purpose of the use or disclosure. UAMS Minimum Necessary Policy, 3.1.25.
NUMBER: 3.1.37  
DATE: 04/01/03  
REVISION: 03/01/04  

SECTION: GENERAL ADMINISTRATION  
AREA: ADMINISTRATION  
SUBJECT: VERIFICATION OF IDENTITY POLICY  

SCOPE  
UAMS Workforce  

DEFINITIONS  
The following terms have the same meaning as the terms defined in the HIPAA regulations:  

**Disclosure** means the release, transfer, providing access to, or divulging of Protected Health Information in any manner outside of UAMS.  

**Protected Health Information (PHI)** means information that is part of an individual’s health information that identifies the individual or there is a reasonable basis to believe the information could be used to identify the individual, including demographic information, and that (i) relates to the past, present or future physical or mental health or condition of the individual; (ii) relates to the provision of health care services to the individual; or (iii) relates to the past, present, or future payment for the provision of health care services to an individual. This includes PHI which is recorded or transmitted in any form or medium (verbally, or in writing, or electronically). PHI excludes health information maintained in educational records covered by the federal Family Educational Rights Privacy Act and health information about UAMS employees maintained by UAMS in its role as an employer.  

**UAMS Workforce** means physicians, employees, volunteers, residents, students, trainees, visiting faculty, and other persons whose conduct, in the performance of work for UAMS, is under the direct control of UAMS, whether or not they are paid by UAMS.  

POLICY  
Prior to disclosing any Protected Health Information, UAMS will verify the identity and authority of all individuals requesting Protected Health Information, including access to or a copy of Protected Health Information, if the identity or authority of such individuals is not known.  

PROCEDURE  

A. **General -- Verification of Identity/Authority:** If the identity or authority of a person requesting PHI is not known to the UAMS workforce member responding to the request, the identity and authority of that person shall be verified prior to providing any PHI.  

B. **How to Verify Identity:** Prior to disclosing any PHI, and if identity of the person requesting PHI is not known, the UAMS workforce will request information to verify the identity of the requesting party, such as the person’s valid driver’s license with a photograph. To verify identity of public officials, see “Identity of Public Officials” section of this Policy.
C. **How to Verify Authority:** The UAMS workforce will obtain any documentation, statements, or representations, whether oral or written, from the person requesting the PHI when the authority of the person to receive the PHI is not known.

For Example: Prior to disclosing PHI to a person claiming to have legal authority to act on behalf of a patient, UAMS will request a copy of the document appointing the person with such legal authority, such as a Durable Power of Attorney including healthcare decisions, a Health Care Proxy appointing a person to make healthcare decisions for the patient, a court order appointing a Guardian for the patient, a court order appointing an Administrator or Executor or Personal Representative (or similar title) of the Estate of a deceased person.

D. **Examples for Verifying Identity and Authority when it is not known to you:** Individual departments should develop procedures for verifying identity and authority that are tailored to their specific work areas. The following are examples that may be used to verify identity and authority:

1. **If the requestor is a patient:** Only the identity of the patient needs to be verified, such as a combination of full name and date of birth, and last four digits of Social Security number or other demographic information checked against documentation in our system.

2. **If the requestor is a family member:** Their name, relationship to the patient and the ability to provide specific identifying information regarding the patient may be used to verify identity. To verify authority to obtain patient information, check for documentation in the patient’s record regarding their authority to receive information about the patient. If no such documentation, you may ask for the patient to call back to provide verbal permission to speak with the family member or ask for a copy of the document establishing the authority.

3. **If the requestor is a UAMS Employee:** Viewing their UAMS I.D. Badge or obtaining their name, phone number and department or UAMS billing number and determining the purpose of the request for information.

4. **If the requestor is a non-UAMS provider or other covered entity:** Their name, phone number and organization’s name plus the ability to provide specific identifying information regarding the patient, and the purpose for the request, such as for treatment or payment. When in doubt call the number back or ask them to fax a written request on company letterhead.

E. **Identity of Public Officials:** UAMS may rely, if such reliance is reasonable under the circumstances, on any of the following to verify identity when the disclosure of PHI is to a public official or a person acting on behalf of the public official:

1. If the request is made in person, presentation of an agency identification badge, other official credentials, or other proof of government status; or

2. If the request is in writing, the request is on the appropriate government letterhead; or

3. If the disclosure is to a person acting on behalf of a public official, a written statement on appropriate government letterhead that the person is acting under the government’s authority or other evidence or documentation of agency, such as a contract for services, memoranda of understanding, or purchase order, that establishes that the person is acting on behalf of the public official.

UAMS may rely, if such reliance is reasonable under the circumstances, on documentation, statements, or representations that, on their face, reflect that the requesting party has authority to obtain the information.
F. Authority of Public Official: UAMS may rely, if such reliance is reasonable under the circumstances, on any of the following to verify authority when the disclosure of PHI is to a public official or a person acting on behalf of the public official:

1. A written statement of the legal authority under which the information is requested, or, if a written statement would be impracticable, an oral statement of such legal authority; or

2. If a request is made pursuant to a warrant, order, or other legal process issued by a grand jury or a judicial or administrative tribunal, the legal authority may be presumed to exist, and the UAMS workforce must obtain a copy of the document and contact the UAMS Office of General Counsel.

G. Exceptions to Verification of Identity/Authority Requirements:

1. Patient Directory: UAMS is not required to verify the identity or authority of a person prior to disclosing information from the Patient Directory, as long as the patient has not opted out of the Patient Directory. If the patient has not opted out of the Patient Directory, the information which may be disclosed is limited to the patient’s location in the facility and a one-word general statement of the patient’s condition, and this information may be shared with any person who identifies the patient by name. See the “UAMS, 3.1.20 Release of Patient Directory Information Policy” for more information.

2. When Patient Has Signed Authorization Form and PHI is to be Mailed: When a patient has provided to UAMS a signed Authorization form (original or a copy) requesting release of his/her PHI to another party, and UAMS is mailing the PHI to the name and address stated in the Authorization Form, UAMS is not required to verify the identity or authority of the party designated by the patient to receive the information. (Note: The Authorization must contain the elements required by HIPAA, or the UAMS Authorization for Release of Information Form attached to the UAMS Use and Disclosure of PHI and Medical Records Policy, 3.1.28, must be used.)

3. When Patient Has Signed Authorization Form and PHI is to be Released Over the Phone or Picked Up, Verify Identity, but Not Authority: When a patient has provided to UAMS a signed Authorization Form (original or a copy) requesting release of his/her PHI to another party, and UAMS is to release the information over the phone, or the information is to be picked up by the designated party, UAMS is not required to verify the authority of the party designated by the patient to receive the information. The authority of that person is created by virtue of the patient designating the person in the Authorization Form. However, the identity of the person must be verified to confirm that the person requesting the PHI by phone or in person is the same person who is named in the patient’s authorization form.

For example: UAMS may request to see a valid driver’s license with the person’s picture to verify their identity. (Note: The Authorization Form must contain the elements required by HIPAA, or the UAMS Authorization for Release of Information form attached to the UAMS Use and Disclosure of PHI and Medical Records Policy must be used.)

4. Verifying Identity/Authority of Family/Friends Involved in Care When Patient Present: As long as the patient’s identity is known, UAMS workforce are not required to verify the identity or authority of person that the patient identifies as being a member of the patient’s family, a friend or other person directly involved in the patient’s care, and the patient is present on the phone or in person when the identification is made.

For example: If a family member calls for PHI, and the patient is present during the phone call and informs the UAMS workforce member on the phone that UAMS can share the PHI being requested with the family member, UAMS is not required to verify the identity or authority of the family member at that time. In this circumstance, UAMS would verify that it is the patient who is on the phone, but would not need to verify the identity or authority of the family member. See UAMS Use and Disclosure of PHI and
If the friend or family member claims to be a legal representative or otherwise has some type of legal authority to act on behalf of the patient in the patient’s absence, this is a different situation, and UAMS will refer to the Use and Disclosure of PHI and Medical Records Policy regarding legal representatives, and also refer to the “Verification of Authority” Section C of this Policy.
UAMS ADMINISTRATIVE GUIDE

NUMBER: 3.1.40
DATE: 04/01/05
REVISION:

SECTION:  ADMINISTRATION
AREA:  GENERAL ADMINISTRATION
SUBJECT: WORKING FROM HOME

SCOPE

UAMS Workforce with Access to Confidential Information, including Electronic Protected Health Information (ePHI), for any purpose.

DEFINITIONS

UAMS Workforce means employees, physicians, volunteers, residents, students, trainees, visiting faculty, and other persons whose conduct, in the performance of work for UAMS, is under the direct control of UAMS, whether or not they are paid by UAMS.

Confidential Information includes information concerning UAMS research projects, confidential employee information, information concerning the UAMS research programs, proprietary information of UAMS, and sign-on and password codes for access to UAMS computer systems. Confidential information shall include Protected Health Information.

Protected Health Information (PHI) means information that is part of an individual’s health information that identifies the individual or there is a reasonable basis to believe the information could be used to identify the individual, including demographic information, and that (i) relates to the past, present or future physical or mental health or condition of the individual; (ii) relates to the provision of health care services to the individual; or (iii) relates to the past, present, or future payment for the provision of health care services to an individual. This includes PHI which is recorded or transmitted in any form or medium (verbally, or in writing, or electronically). PHI excludes health information maintained in educational records covered by the federal Family Educational Rights Privacy Act and health information about UAMS employees maintained by UAMS in its role as an employer.

Electronic Protected Health Information (ePHI) means individually identifiable health information that is:

- Transmitted by electronic media
- Maintained in electronic media

Information Systems means an interconnected set of information resources under the same direct management control that shares common functionality. A system normally includes hardware, software, information, data, application, communications, and people.

POLICY

Members of the UAMS Workforce who are assigned to work from home part-time or full-time in an official UAMS capacity are responsible for maintaining the privacy and security of all UAMS Confidential Information including Protected Health Information (PHI) and Electronic Protected Health Information (ePHI) and for

following all UAMS policies and procedures related to Confidential Information, PHI, and ePHI.

**PROCEDURE**

1. Confidential Information, including PHI, is not to be removed from UAMS by members of the Workforce without prior approval and a signed confidentiality agreement on file.

2. The Workforce member is responsible for maintaining the privacy and security of all Confidential Information that they may be transporting, storing or accessing off-site. This includes, but is not limited to:
   
   A. Protected Health Information and Electronic Protected Health Information
   
   B. Computers that contain or access Confidential Information
   
   C. Confidential Working Papers

3. UAMS policies are in effect whether the Workforce member is working off-site or in a UAMS facility. The following safeguards must be acknowledged:
   
   A. IT Network Security 7.3.08
      
      1. Any Confidential Information or ePHI sent from workstations, laptops, PDAs and other mobile devices must be encrypted.
   
   B. Safeguarding PHI Policy 3.1.38
      
      1. Electronic media and printed information must be transported and stored in a secure manner.
      
      2. All media containing PHI or ePHI must be disposed of appropriately and must never be placed in regular trash. This includes printed information, faxes, hard drives, diskettes and CDs.
      
      3. UAMS materials must be put away when not being used and kept in a secure location that is not accessible to others including children, spouse and visitors.
   
   C. Mobile Device Safeguards #3.1.17 and HIPAA Security Protection from Malicious Software 7.3.15
      
      1. Anti-virus software must be installed on all home computers and mobile devices used for UAMS business, and they must be password protected.
      
      2. Employees are required to maintain updates to current operating systems (ex. Microsoft updates/patches)
   
   D. Confidentiality Policy #3.1.15
      
      1. Passwords must not be shared or accessible to family members or others.
   
   E. The printing of confidential information from home computers should be kept to a minimum and only as needed in accordance with UAMS policies.

4. UAMS Workforce Members who are assigned to work from home part-time or full-time in an official UAMS capacity involving Confidential Information must sign the formal “UAMS Work

at Home Agreement.” The agreement consists of UAMS Campus Requirements for Working from home and a section for departments to add guidelines specific to their area, if desired. For example, departments might consider including: who will bear the cost and installation of equipment, phone lines, and the replacement of any UAMS equipment that is stolen or destroyed; measures for maintaining productivity and quality; attendance at meetings; recording time worked; or other requirements.

5. UAMS will provide to the Workforce Member access to or a copy of the following UAMS Policies from the Administrative Guide:

   A. 3.1.40 Working at Home
   B. 3.1.15 Confidentiality Policy
   C. 3.1.38 Safeguarding of PHI Policy
   D. 7.3.08 IT Network Security
   E. 3.1.17 Mobile Device Safeguards
   F. 7.3.15 HIPAA Security Protection from Malicious Software

6. UAMS equipment taken home requires a signed UAMS Property Located Off-Campus Form.

7. Employees and/or supervisors may contact IT to verify software or hardware compliance.

UAMS Work-at-Home Agreement

UAMS Campus Requirements.

(These items must be a part of all Work-at-Home Agreements)

1. I have received, agree to and abide by the following UAMS Administrative Guide Policies:

   A. 3.1.40 Working at Home
   B. 3.1.15 Confidentiality Policy
   C. 3.1.38 Safeguarding of PHI Policy
   D. 7.3.08 IT Network Security
   E. 3.1.17 Mobile Device Safeguards
   F. 7.3.15 HIPAA Security Protection from Malicious Software

2. I agree to maintain the privacy and security of all UAMS Confidential Information including Protected Health Information (PHI) and Electronic Protected Health Information (ePHI) and agree to access, use
and disclose in accordance with all applicable UAMS policies and procedures.

3. As with all UAMS workforce, I understand that my work is subject to auditing and I will cooperate with any requirements of the UAMS auditing process.

4. I agree to maintain current anti-virus software, spyware protection, and operating systems updates on my computer.

5. I understand that any violations of this agreement or UAMS policies and procedures are subject to disciplinary action up to and including termination.

..............................................................................................................................................................................................................

Department Specific Requirements, if any:

(Optional):

________________________________________________________

Employee signature                                      date

Employee address where work will be performed

Employee phone number

Staff:
Provide a copy of the signed agreement to the employee, a copy to UAMS OHR for the employee’s personnel file, and maintain the original in the department file.
8. **UAMS Policies on Research and Grant Awards**

- Authority of the Institutional Review Board  
  (Executive Memorandum)

- Compensation for Employee Participation in Research  
  (Admin Policy 4.2.13)

- Distribution of Royalties from Patents, Copyrights and Licenses  
  (Admin Policy 12.1.01)

- Ethical Standards in Research and Procedure  
  (Admin Policy 12.1.01)

- Grants and Contracts Proposal/Award Procedures  
  (Admin Policy 12.1.01)

- Mandatory Education Policy for Investigators/Study Personnel Participating in Human Subject Research Projects  
  (Admin Policy 12.1.01)

- Responsibilities of the Central Administration  
  (Admin Policy 12.1.01)

- Responsibilities of the Principal Investigators  
  (Admin Policy 12.1.01)

The complete UAMS Administrative Guide may be found at [http://uams.edu/AdminGuide/index.html](http://uams.edu/AdminGuide/index.html)

**Research Administration and Support Units**

A number of units are available to UAMS faculty involved in research, including those located at the VA and Arkansas Children's Hospital, including:

- Arkansas Children's Hospital Research Institute
- Automated Research Information Administrator (ARIA)
- General Clinical Research Center
- Office of Clinical Trials
- Office of Grants & Scientific Publications
- Office of Research and Sponsored Programs
  - Institutional Review Board (Human Subject review)
  - Investigators' Handbook
- Office of Research Compliance

[Back](http://www.uams.edu/academicaffairs/facultyresources/research.asp)
Executive Memorandum

DATE: 8/13/2004
REVISION:

SECTION: ACADEMIC AFFAIRS RESEARCH
AREA: ADMINISTRATION
SUBJECT: Authority of the Institutional Review Board (IRB)

Policy

The IRB has the authority to review all research conducted by UAMS faculty, staff and students to ensure that human subjects involved in research activities are given the broadest protections provided by the canons of ethical research, applicable federal, state, and local laws and regulations, institutional guidelines, and common practice guidelines as set forth by the International Committee on Harmonisation.

The IRB will function as an independent and autonomous deliberative body within the University, free of undue influence on its judgments regarding the appropriateness of research and protections afforded human participants. Organizationally, the IRB will operate under the auspices of a Human Research Subjects Protection Program that provides for management by the campus’ senior science officer, the Vice Chancellor for Academic Affairs/Research Administration (the VCAA), who in turn reports directly to the campus’ chief executive, the Chancellor.

The IRB has the right to constitute itself with regard to structure, governance, and operating principles (within its management framework), that it determines most effective in pursuing its mission to protect human research subjects under its purview, whether at UAMS or other organizations for whom the UAMS IRB conducts research review.

Specific authority is given to the Institutional Review Board (IRB) to:

1. Approve, disapprove, or require modifications of research activities
2. Require progress reports and safety information from the investigators and oversee the conduct of the studies
3. Suspend or terminate approval of an ongoing study.
4. Suspend or terminate an investigator's privileges to conduct research.
5. Reopen terminated/closed protocols and reinstate investigator's privileges.
6. Function as the Institution's privacy board for research.
In its review of human subject research, the IRS has jurisdiction over all aspects of the research including, but not limited to:

1. Methods of identifying potential subjects
2. Methods proposed for contacting potential subjects
3. Materials to recruit subjects and proposed compensation
4. Pilot studies
5. Proposals to use or provide stored blood, tissues, or confidential data
6. Surveys and questionnaires
7. The informed consent process and forms
8. The protocol and summary of the research
9. Evaluation of risks and benefits to subjects
10. Unanticipated problems involving risk to subjects
11. Proposed changes to the research
12. Continuing reviews
13. Use of investigational drugs and devices in emergencies
14. Humanitarian use of drugs and devices
15. Eligibility for exemption or expedited review

In order to approve research, the IRS shall determine that a minimum of all of the following requirements are satisfied

1. Risks to subjects are minimized
2. Risks to subjects are reasonable in relation to anticipated benefits,
3. Selection of subjects is equitable.
4. Informed consent will be sought from each prospective subject or the subject's legally authorized representative.
5. Informed consent will be appropriately documented.
6. The research plan makes adequate provision for monitoring the data collected, when necessary.
7. Provisions to protect the privacy of subjects and to maintain the confidentiality of patient data are adequate, when necessary.

Undue Influence

Individual IRS members, whether employed by the institution or an affiliate or lay members, have both the obligation and right to report any undue pressure upon them to make decisions at the convened IRS meetings that would favor an individual investigator or the institution over the welfare and safety of the research subject. The manner in which the IRS member chooses to report such undue pressure can take various pathways, depending upon the member's perceived need for anonymity. Reports can be made orally or written (with or without identity). Options of reporting are as follows:

IRS Chairman
IRS Administrator
Director of Research Administration
Regardless of the pathway chosen by the IRB member, the Vice Chancellor for Academic Affairs and Sponsored Research at UAMS will be informed by the other individuals and will be responsible for the official investigation of the reported undue pressure. In a timely manner, the Vice Chancellor for Academic Affairs and Sponsored Research at UAMS will inform the IRB member of the investigation findings and actions taken to alleviate the undue pressure.

EXAMPLES:

The IRB member is an Assistant Professor in an academic department and is due for consideration of promotion and tenure. A full Professor in the department who is on the Promotion and Tenure Committee has a grant that has received a favorable score for funding but the IRB has found problems with the protocol and consent as written that has resulted in what the full Professor considers needless delays. The full Professor goes to the IRB member and seeks to have him disclose proceedings of the convened IRB at which his protocol was discussed and voted on. Particularly, the full Professor desires to obtain names of IRB Committee members who reviewed and/or spoke up against his protocol or voted in an unfavorable manner so he can contact them to express his displeasure and perhaps even to make waves with the Dean. Because the IRB member knows that all proceedings of the convened meetings are confidential, he must refuse the full Professor's request and report the incident.

A Departmental Chairman requests that an IRB member, who is a senior faculty member in their department come by for a visit. The Chairman expresses concern that the IRB committee has been making too many unfavorable decisions regarding protocols submitted by persons in the department. The IRB member is requested to divulge information concerning how the convened IRB Committee makes decisions and how the process could be made more favorable to applications from the department. Specific protocols are not discussed but it is obvious that the Chairman is seeking to "take names and kick butt" to influence decisions made by the IRB. The IRB member knowing of the confidential nature of all IRB proceedings, respectfully suggests that the Chairman should schedule a meeting with the IRB Chairman and the Vice Chancellor for Academic Affairs and Sponsored Research at UAMS to discuss how the IRB could better educate researchers in Federal regulations and the need for more guidance in preparing protocol submissions for IRB consideration.

A lay member of the IRB, who is not affiliated with the institution, is contacted by a reporter for the local newspaper. There has been an unexpected death in a research study and the reporter is investigating the death following prompting by the family of the deceased. The reporter has found the name of the lay member from the IRB web site and believes that since she is not affiliated with the institution information might be available that would not be forthcoming from other IRB members. Particularly, the reporter is interested in information concerning how the IRB approved the study and information concerning how the death was reported to the Committee. The lay member is courteous to the reporter but lets him know that all proceedings of the IRB Committee are confidential and that any release of information will have to come from the Vice Chancellor for Academic Affairs and Sponsored Research at UAMS. The lay member then reports the incident.

I. Dodd Wilson, M.D.
Chancellor

Date
UAMS ADMINISTRATIVE GUIDE

NUMBER: 4.2.13
DATE: 09/15/2004
REVISION:

SECTION: HUMAN RESOURCES
AREA: COMPENSATION
SUBJECT: COMPENSATION FOR EMPLOYEE PARTICIPATION IN RESEARCH

POLICY

UAMS recognizes that UAMS employees can contribute to the work of the University by participating in research projects as human subjects. In this regard, such activities are beyond the scope of any job description, and the participating employee may be paid above his normal salary for such activities. However, the amount must be included in total employee compensation for tax purposes. These procedures will establish uniform guidelines for such payments.

PROCEDURE

1. Employees (classified and non-classified) may be paid additional amounts for their voluntary participation as subjects of UAMS research in amounts determined by the Principal Investigator. The amount of compensation, when added to regular salary, may not exceed the Line Item Maximum salary established for the regular position of the participating employee.

2. The project must be one which conforms to Administrative Guide section 12.1, Research Administration, and is formally approved by the UAMS Human Research Advisory Committee (HRAC). See http://www.uams.edu/ora/irb/index.htm

3. If time off is taken for this participation, the employee must coordinate this with the supervisor or department head: vacation/annual leave may be charged to the employee.

4. Following the completion of tasks or services by the employee, the Principal Investigator or his business manager will submit a request for payment: Please click here and use this template for payment.

5. When approved, the request will be forwarded to Finance/Payroll for payment.

6. All payments to employees will be paid through normal payroll process and will be subject to all taxes and mandatory withholdings. Such payments are not eligible for retirement contribution or employer matching.

REFERENCE

1 UAMS Policy 12.01.03
The purpose of this policy is to notify colleges and researchers within the University of Arkansas for Medical Sciences (UAMS) of the procedures that are followed when allocating the costs and the distribution of income resulting from a successful patent, copyright or license.

It is the policy of the University of Arkansas to acquire and retain legal title to all inventions created by any person or persons to whom this policy is applicable. This policy is established in furtherance of the commitment of the University to the widest possible distribution of the benefits of University Research, the protection of Inventions resulting from such research, and the development of Inventions for the public good.

This policy shall apply to all persons employed, compensated, or appointed by the University and to anyone using facilities owned, operated, or controlled by the University. It shall also apply to all Inventions financed, in whole or in part, from funds under the control of UAMS.

1. All persons to whom this policy is applicable shall petition the UAMS Patent and Copyright Committee of their intent to seek a patent or copyright. The Patent and Copyright Committee will decide whether to seek the patent, copyright or license; release the petitioner; or take no action.
2. The UAMS Patent and Copyright Committee will notify the General Counsel of the University of Arkansas System if they wish to seek a patent or copyright. The General Counsel’s Office will obtain Counsel on behalf on the University and the petitioner. The legal costs related to the application of the patent, copyright, or license are charged back to UAMS.
3. Once a patent, copyright, or license is obtained, sale of the patent, copyright, or license is negotiated by the UAMS Office of Research Administration and the General Counsel of the University of Arkansas System together with the appropriate college or the researcher.
4. When a contract is approved and payment is received by the Controller’s Office it will be deposited into the Patent, Copyright and License Control Account. The Controller’s office will make distribution within 30 days of deposit of the royalty payment in the UAMS Treasurer’s Office. The Controller’s Office will reduce the payment amount by the actual costs for patenting, licensing, and the protection of patent rights and copyrights. If the cost of obtaining the patent, copyright, or license exceed 20% of the initial payment, only 20% will be charged against the initial payment. The balance of the costs will be charged against succeeding payments, with a maximum of 20% of any single payment being charged, until all costs are covered. The net distribution will be as follows:

For net royalty proceeds for income up to $200,000: For Income over $200,000
50% to the Inventor(s) 35% to Inventor(s)
5% to the U of A System 5% to U of A System
31.5% to the Appropriate College 42% to Appropriate College
13.5% to the Chancellor & Processing Reserve 18% to Chancellor & Processing Reserve

For example, if a patent is sold for $100,000, and legal costs were $10,000, the net proceeds of $90,000 will be distributed as follow:

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross Receipt</td>
<td>$100,000</td>
</tr>
<tr>
<td>Less: Direct Costs</td>
<td>10,000</td>
</tr>
<tr>
<td>Available for Distribution</td>
<td>90,000</td>
</tr>
<tr>
<td>Distribute to Inventor (50%)</td>
<td>45,000</td>
</tr>
</tbody>
</table>
If a patent sold for $300,000, and legal costs were $10,000 the net proceeds of $290,000 will be distributed as follows:

<table>
<thead>
<tr>
<th>Distribution Category</th>
<th>Percentage</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross Receipt</td>
<td></td>
<td>$300,000</td>
</tr>
<tr>
<td>Less: Direct Costs</td>
<td></td>
<td>$10,000</td>
</tr>
<tr>
<td>Available for Distribution</td>
<td></td>
<td>$290,000</td>
</tr>
</tbody>
</table>

**First $200,000**  **Additional $90,000**

<table>
<thead>
<tr>
<th>Distribution Category</th>
<th>Percentage</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Distribute to Inventor (50%)</td>
<td>(35%)</td>
<td>31,500</td>
</tr>
<tr>
<td>Distribute to UA System (5%)</td>
<td>(5%)</td>
<td>4,500</td>
</tr>
<tr>
<td>Distribute to Appropriate College (31.5%)</td>
<td>(42%)</td>
<td>37,800</td>
</tr>
<tr>
<td>Distribute to Chancellor (13.5%)</td>
<td>(18%)</td>
<td>16,200</td>
</tr>
</tbody>
</table>

5. Contact the Office of Research Administration for assistance and additional information.

1. UofA Board Policy 210.1 - Patent and Copyright Policy
PURPOSE

The purpose of this policy is to maintain the research credibility of the faculty, staff and the University of Arkansas for Medical Sciences campus so that there will be public confidence in scientific research and any injury to the public interest will be avoided. It is recognized that, as is the case with all human endeavors, honest mistakes will occur in the conduct of scientific research. Therefore, investigators who inadvertently make errors in either the planning, execution or interpretation of scientific research shall not be considered in violation of the policy contained within this document.

POLICY

It is the policy of the University of Arkansas for Medical Sciences (UAMS) that all scientific research engaged in by faculty and staff of this campus must be conducted, and the results reported, with integrity. Indicated research must have actually been performed. Data must be verified and academic honesty must prevail. Research findings must be fairly attributed as to their authors. Research results are to be documented and comply with federal requirements that uniquely relate to the conduct of that research. The following conduct, which this policy addresses, constitutes scientific misconduct and includes, but is not limited to:

- Knowingly misrepresenting or falsifying research data.
- Intentionally concealing actual facts material to research results reported, or falsely representing actual facts discovered which are material to research results reported.
- Filing research reports and/or publishing research findings without having done the research indicated.
- Falsely claiming to be the author of research which was performed by others.
- Deceitfully reporting research of others as one’s own and/or plagiarism involving the work of others.
- Material failure to comply with federal requirements that uniquely relate to the conduct of research. This would include, but not be limited to, failure to comply with federal requirements for protection of human subjects or for ensuring the welfare of laboratory animals.

Research at UAMS is expected to be conducted with full regard for the academic freedom of those so involved, and with the responsibility for insuring that the intentional perversion or suppression of truth does not compromise scientific research in the medical sciences. Scientific misconduct undermines the methods and purposes of those scientists using acknowledged research methods.

Principal investigators and laboratory directors are ultimately responsible for the supervision and verification of research programs and personnel in their laboratories. This responsibility includes the maintenance of accurate and reliable records and data, the preparation of quality research papers, and the assurance that the authors of papers have actually contributed to the research efforts reported.

A charge of scientific misconduct is a most serious charge. For that reason, the Vice Chancellor, the review committees and all others involved in the inquiry or investigation shall take whatever actions are necessary to protect, to the maximum extent possible, the privacy of those who, in good faith, report apparent misconduct. In addition, the Vice Chancellor, the review committees and all others involved in the inquiry shall afford the affected individual(s) confidential treatment to the maximum extent possible. Further, should the charge not be sustained, formal and extensive efforts are to be made so that the reputation of the person against whom the charge was made shall not be impaired. Charges made maliciously and in bad faith, after so found, shall lead to employee disciplinary action.

PROCEDURE (GENERAL)

1. Initial reports that scientific misconduct may have occurred are to be made to the Vice Chancellor for Academic Affairs, hereafter referred to as the Vice Chancellor. The Vice Chancellor must then inform the Dean(s) of the College(s) of the person making the initial report and of the person so charged. In certain instances, others, as required by law, regulation or contract, may also be notified at this
PROCEDURE (INITIAL INQUIRY)

2. The initial inquiry of the charge that scientific misconduct may have occurred must be by an internal review panel of full time UAMS faculty members, termed the Inquiry Committee. This inquiry must be completed within 60 calendar days of its initiation, i.e., from the time of receipt of the initial allegation by the Vice Chancellor, unless circumstances clearly warrant a longer period. If the inquiry takes longer than 60 days to complete, the record of the inquiry must include documentation of the reasons for exceeding the 60 day period.

3. The Vice Chancellor, in consultation with the Dean of the person so charged, must prepare a list of potential committee members from the UAMS faculty roster, making every effort in the selection process to form an Inquiry Committee with the appropriate scientific expertise. This list must be presented to the person so charged and he/she may request that any potential member not be impanelled by submitting to the Vice Chancellor a written explanation of why the person(s) should not serve on the committee. The Vice Chancellor, in consultation with the Dean of the person so charged, must decide on the validity of the challenge to any potential committee member, and choose six members to serve as the Inquiry Committee. Once formed, the Inquiry Committee must elect one of its members to assume the role of chairman.

4. The members of the Inquiry Committee must have no real or apparent conflict of interest and will be asked to sign a statement to this effect. Any relationship with the involved parties must be disclosed to those involved in the inquiry. Any member of the Inquiry Committee with a conflict of interest must be replaced with a member selected by the Vice Chancellor.

5. The Vice Chancellor is to be present in a non-voting capacity at all committee meetings to provide procedural advice to the committee. The Vice Chancellor must appoint an Investigative Committee. It is to consist of six members, at least four of whom are full-time faculty members, termed the Inquiry Committee. This inquiry must be completed within 60 calendar days of its initiation, i.e., from the time of receipt of the initial allegation by the Vice Chancellor, unless circumstances clearly warrant a longer period. If the inquiry takes longer than 60 days to complete, the record of the inquiry must include documentation of the reasons for exceeding the 60 day period.

6. The members of the Inquiry Committee must have no real or apparent conflict of interest and will be asked to sign a statement to this effect. Any relationship with the involved parties must be disclosed to those involved in the inquiry. Any member of the Inquiry Committee with a conflict of interest must be replaced with a member selected by the Vice Chancellor.

7. The Vice Chancellor is to be present in a non-voting capacity at all committee meetings to provide procedural advice to the committee. The Vice Chancellor must appoint an Investigative Committee. It is to consist of six members, at least four of whom are full-time faculty members, termed the Inquiry Committee. This inquiry must be completed within 60 calendar days of its initiation, i.e., from the time of receipt of the initial allegation by the Vice Chancellor, unless circumstances clearly warrant a longer period. If the inquiry takes longer than 60 days to complete, the record of the inquiry must include documentation of the reasons for exceeding the 60 day period.

PROCEDURE (INVESTIGATIVE REVIEW)

10. If the Inquiry Committee finds that an investigation is warranted, the Vice Chancellor must initiate the investigation by impaneling an Investigative Committee within 30 days of receiving the report of the Inquiry Committee. This investigation should ordinarily be completed within 120 days of its initiation. However, if this deadline cannot be met and the project(s) involve federally-funded research, then a written request for an extension must be submitted to the appropriate office as required by federal regulations.

11. The Vice Chancellor, in consultation with the Dean of the person so charged, must prepare a list of potential committee members, making every effort in the selection process to form an Investigative Committee with the appropriate scientific expertise. This list must be presented to the person so charged and he/she may request that any potential member not be impanelled by submitting to the Vice Chancellor a written explanation of why the person(s) should not serve on the Committee. The Vice Chancellor, in consultation with the Dean, will then decide on the validity of the challenge to any potential committee member.

12. The Vice Chancellor must appoint an Investigative Committee. It is to consist of six members, at least four of whom are full-time faculty members of UAMS at the rank of associate or full professor. Up to two scientists who are not employees of the University of Arkansas for Medical Sciences, each of whom must be personally qualified to judge the scientific nature of the research work, may also be appointed to the Committee. Once formed, the Investigative Committee must elect one of its members to assume the role of chairman.

13. The members of the Investigative Committee must have no real or apparent conflict of interest and will be asked to sign a statement to this effect. Any relationship with the involved parties must be disclosed to those involved in the investigation. Any member of the Investigative Committee with a conflict of interest must be replaced with a member selected by the Vice Chancellor.

14. The Vice Chancellor is to be present in a non-voting capacity at all committee meetings to provide procedural advice to the committee members. At his/her discretion, the Dean or his/her designee of the college of the charged person may also be present in a non-voting capacity. The Vice Chancellor must appoint an Investigative Committee. It is to consist of six members, at least four of whom are full-time faculty members, termed the Inquiry Committee. This inquiry must be completed within 60 calendar days of its initiation, i.e., from the time of receipt of the initial allegation by the Vice Chancellor, unless circumstances clearly warrant a longer period. If the inquiry takes longer than 60 days to complete, the record of the inquiry must include documentation of the reasons for exceeding the 60 day period.

15. The Vice Chancellor is to be present in a non-voting capacity at all committee meetings to provide procedural advice to the committee. The Vice Chancellor must appoint an Investigative Committee. It is to consist of six members, at least four of whom are full-time faculty members, termed the Inquiry Committee. This inquiry must be completed within 60 calendar days of its initiation, i.e., from the time of receipt of the initial allegation by the Vice Chancellor, unless circumstances clearly warrant a longer period. If the inquiry takes longer than 60 days to complete, the record of the inquiry must include documentation of the reasons for exceeding the 60 day period.

16. The Vice Chancellor is to be present in a non-voting capacity at all committee meetings to provide procedural advice to the committee. The Vice Chancellor must appoint an Investigative Committee. It is to consist of six members, at least four of whom are full-time faculty members, termed the Inquiry Committee. This inquiry must be completed within 60 calendar days of its initiation, i.e., from the time of receipt of the initial allegation by the Vice Chancellor, unless circumstances clearly warrant a longer period. If the inquiry takes longer than 60 days to complete, the record of the inquiry must include documentation of the reasons for exceeding the 60 day period.

17. The Vice Chancellor is to be present in a non-voting capacity at all committee meetings to provide procedural advice to the committee. The Vice Chancellor must appoint an Investigative Committee. It is to consist of six members, at least four of whom are full-time faculty members, termed the Inquiry Committee. This inquiry must be completed within 60 calendar days of its initiation, i.e., from the time of receipt of the initial allegation by the Vice Chancellor, unless circumstances clearly warrant a longer period. If the inquiry takes longer than 60 days to complete, the record of the inquiry must include documentation of the reasons for exceeding the 60 day period.
capacity. Legal counsel or another advisor may be present during meetings of the Investigative Committee in which the person so charged is interviewed to provide advice but may not address the committee. Only the person giving testimony to the committee, and the above noted exceptions, may be present in any committee meeting.

15. The Investigative Committee shall investigate fully to determine if scientific misconduct, as defined by this policy, has occurred. In doing so, it may utilize any files developed by the Inquiry Committee and may review any additional evidence deemed relevant through procedures adopted by the panel. The Committee must secure necessary and appropriate expertise to carry out a thorough and authoritative evaluation of the relevant evidence. The investigation normally will include examination of all documentation, including, but not necessarily limited to, relevant research data and proposals, publications, correspondence, and memoranda of telephone calls. Whenever possible, interviews should be conducted of all individuals involved either in making the allegation or against whom the allegation is made, as well as other individuals who might have information regarding key aspects of the allegations. Complete summaries of these interviews should be prepared, provided to the interviewed party for comment or revision, and included as part of the investigatory file. All involved parties are obligated to cooperate fully with the proceedings of the Investigative Committee. Funding agencies must be kept apprised of developments during the course of the investigation, as required by law, regulation or contract.

16. The Investigative Committee must determine, by a majority vote of its members, whether scientific misconduct has been proven by a preponderance of the evidence, and if so, must recommend sanctions.

17. The Investigative Committee must provide a written report of its findings to the Vice Chancellor, the Dean(s) of the person charged and the person making the charge, the person making the charge, the person(s) so charged and others to the extent required by law, regulation or contract. The report shall include the documentation which supports the committee's findings. Only the Vice Chancellor may release a copy of this personnel determination to third parties. Reports from the Investigative Committee must, otherwise, remain confidential and must be secured in the Office of the Vice Chancellor. All records must be maintained for a period of at least three years after the termination of the investigation.

18. If the Investigative Committee does not find that scientific misconduct has occurred, the Vice Chancellor must, to the maximum extent possible, take steps to minimize the damage to reputations which may result from inaccurate reports.

PROCEDURE (APPEALS PROCESS)

19. The decision of the Investigative Committee may be appealed. Appeals are made to the Chancellor of UAMS and must be filed within seven days of the Investigative Committee's decision. Any such appeal will be limited to the evidence presented during the investigative review and the grounds for appeal are limited to failure of the Investigative Committee to follow appropriate procedures or that an arbitrary decision was made. New evidence contained within the appeal may warrant a reopening of the investigation. The decision of the Chancellor is final.

PROCEDURE (SANCTIONS)

20. If the Investigative Committee finds that scientific misconduct has occurred, the Vice Chancellor and the Dean of the person so charged, with due consideration of the recommendation of the Investigative Committee, must recommend to the Chancellor sanctions to be imposed. The Chancellor must then impose sanctions in accordance with UAMS personnel policies after the conclusion of the appeals process.

PROCEDURE (FEDERAL POLICY)

21. The Vice Chancellor must notify the Office of Scientific Integrity (OSI), in accordance to Federal Policy (Federal Register 54:32450, 50.103d) when, on the basis of an initial inquiry, the institution determines that an investigation is warranted, or, prior to the decision to initiate an investigation, if any of the following conditions exist:

a. There is an immediate health hazard involved.
b. There is an immediate need to protect Federal funds or equipment
c. There is an immediate need to protect the interests of the person(s) making the allegations or of the individual(s) who is the subject of the allegations as well as his/her co-investigators and associates, if any.
d. It is probable that the alleged incident is going to be reported publicly.
e. There is a reasonable indication of possible criminal violation. In that instance, the Vice Chancellor must inform the OSI within 24 hours of obtaining that information.

REFERENCE
1 UAMS Policy 12.1.03
POLICY

The Office of Research Administration (ORA) supports the sponsored research efforts of departments within the University of Arkansas for Medical Sciences. ORA concentrates the functions required to process research applications and to provide information and advice related to the University's sponsored research program. The ORA staff operate with the goal of detailing the administrative/accounting aspects of sponsored research while maintaining a necessary level of coordination between the activities of principal investigators and project directors and the rules and regulations under which the University operates. The ORA offers services in the areas of research administration, sponsored research funding source identification, proposal development, faculty research interest identification, research sponsor interface, contracts, and subcontracts.

PROCEDURE

1. The ORA serves as the central information and clearance office for matters of sponsored research or related administration issues. The ORA offers services such as; formatting and calculating proposal budgets, obtaining acceptance signatures for awards received, providing research administrative statistics, developing and producing research-related agreements and other sub-awards.
2. The staff of the ORA assist in identifying sources of potential funding for researchers and contacting potential sponsors for investigators.
3. The ORA staff is available to assist researchers in the grantsmanship process. The staff coordinates researchers’ interest with the extramural research requirements of sponsor agencies. An additional function of the ORA staff is making enquiries regarding funding needs of investigators and the status of their applications.
4. Specific instructions on developing and writing proposals may be found in Appendix J of the Research Administration Guide.
5. Contact the Office of Research Administration at extension 65502 for assistance and additional information.
UAMS ADMINISTRATIVE GUIDE

NUMBER: 12.1.06
DATE: 07/15/96
REVISION:07/01/03

SECTION: ACADEMIC AFFAIRS
AREA: SPONSORED RESEARCH ADMINISTRATION
SUBJECT: MANDATORY EDUCATION POLICY FOR INVESTIGATORS/STUDY PERSONNEL PARTICIPATING IN HUMAN SUBJECT RESEARCH PROJECTS

PURPOSE
The purpose of this policy is to define the Human Subject Protection educational requirements for investigators and key personnel involved in human subject research overseen by the University of Arkansas for Medical Sciences Institutional Review Board (UAMS IRB).

POLICY
Recognizing the complexity of the federal, state, and campus policies and regulations created to adequately protect the rights of human subjects in research, UAMS has adopted the mandatory education program outlined below for all IRB members, Principal Investigators, and all key research staff having contact with human subjects, human subject data, or biological specimens. Key research staff may be defined as those persons whose responsibilities may include, but are not limited to, day-to-day protocol decision-making related to the study conduct; subject recruitment, selection and eligibility; clarification of the complexities of the protocol to the subject and others; collecting subject information; and entering data.

Recertification is required every two years after completion of the initial educational program requirement.

Accepted Educational Programs

Completion of one of the following educational programs will meet mandatory UAMS requirements for investigators and key personnel involved in human subject research.

1. Successful completion of one of the UAMS web-based tutorial programs on Human Subject Protection AND the HIPAA training course at [http://www.uams.edu/orc/](http://www.uams.edu/orc/). Researchers should complete one of the Human Subject Protection Training Programs appropriate to their research discipline:
   - Biomedical Course on Human Subject Protection Training
   - OR
   - Behavioral and Social Science Course on Human Subject Protection Training

   The Biomedical Course is appropriate for persons whose research involves drugs, devices, and surgical/invasive procedures. The Behavioral and Social Science course is relevant to those disciplines and is not appropriate for investigators whose research involves drugs, devices or surgical/invasive procedures. Both courses integrate UAMS IRB requirements.

   In addition, the on-line HIPAA for Research Training Course is required of all researchers. The HIPAA course is a short overview of the researcher and key research personnel responsibilities for confidentiality, use and disclosure of Protected Health Information obtained during research. UAMS, CAVHS and ACH each have additional policies and procedures to follow regarding HIPAA.

   On-line courses are followed by exams and a record of successful completion is maintained by the Office of Research Compliance. The UAMS IRB will have access to these completion records. This course will be updated quarterly and, if regulatory changes dictate, more frequently by the Office of Research Compliance.

2. Attendance and successful completion of the seminar “Conduct of Human Subjects Studies” sponsored by UAMS and/or ACH will also fulfill the Human Subject Protections Training Requirement. This seminar is scheduled to be taught yearly and includes history, ethics, federal regulations, UAMS IRB procedures, and discussions pertinent to the group’s interests. There is an exam and certificates of training are distributed to attendees if a successful score (80%) is achieved. If an attendee does not achieve an 80% on the initial attempt, the online course and test must be taken and passed.

3. On a case-by-case basis, the UAMS IRB Director and the Office of Research Compliance Director will consider other programs with equivalent or better content to meet this requirement.
Persons should save a copy of printed certificates of completion upon finishing any course other than the UAMS on-line courses.

Who Must Comply With This Policy

The requirement of mandatory completion of the Human Subject Protection Training applies to the following individuals:

1. Investigators (including faculty, residents, and students) submitting a human subjects protocol to the IRB for review and approval.

2. Investigators and persons participating in human subject research, including faculty, residents, and students.

3. Faculty Supervisor of investigator submitting a human subject’s protocol to the IRB for review and approval (if the investigator is a student).

4. Persons responsible for, but not limited to, day-to-day protocol decision-making related to the study conduct; subject recruitment, selection and eligibility; clarification of the complexities of the protocol to the subject and others; collecting subject information; and entering data.

5. Research Coordinators, Research Nurses, and Research Assistants/Associates

6. Members of the UAMS IRB.

Deadline for Compliance

Effective January 31, 2004, all persons to whom this policy applies must have documentation of one of the acceptable courses listed above for Human Subject Protection. Mandatory HIPAA training for researchers was due 4/14/03. Persons without appropriate training may not conduct research after these deadlines.

Continuing Education

Recertification will be required every two years through one of the methods below:

- Re-completion of the web-based tutorial programs at [http://www.uams.edu/orc/](http://www.uams.edu/orc/).

- Re-attendance of the seminar “Conduct of Human Subject Studies”

- Other programs (e.g. Association of Clinical Research Professionals Seminar in Investigator Training) may be an acceptable alternative to the above courses. Please contact the Office of Research Compliance if this is chosen as an option.

Affiliate Institutions Requirements

Arkansas Children’s Hospital

ACH and ACHRI consider this policy as the mandatory base requirements for Human Subject Protection and HIPAA Training on its campus. ACHRI will work with the Office of Research Compliance Educator to enhance the on-line training courses to assure the protection of children in research. Additional courses required by ACH/ACHRI will be announced.

In addition to the UAMS IRB requirements listed above, researchers at CAVHS may have additional educational requirements. The VA R & D Office should be consulted for these requirements

For More Information

Questions concerning this policy should be directed to the UAMS Office of Research Compliance at (501) 526-6876.

Other Contact Numbers:
ACHRI: 501-364-3571
VA R & D: 501-257-4818
PURPOSE

The purpose of this policy is to inform departments within the University of Arkansas for Medical Sciences (UAMS) of the responsibilities held by Central Administration in regard to proposal procedures.

PROCEDURE

1. Central Administration will assist principal investigators/project directors by providing advice regarding potential funding agencies; facilitating communication with those agencies; assisting with the formation of an appropriate proposal budget; reviewing the completed proposal; providing advice regarding post-proposal submittal communication; and helping negotiate all budgetary matters.

2. Central Administration personnel or the Controller's Office will notify principal investigators/project directors of an award and provide appropriate information, account numbers (fund/center numbers), instructions, and copies of award material.

3. Central Administration will review award documents to ensure that their terms are in the best interests of principal investigators/project directors and UAMS; obtain the signature approval (UAMS acceptance) of the appropriate UAMS official for an award; and ensure that UAMS receives funding in accordance with the terms of an award.

4. Central Administration will be responsible for approving all changes to an award to ensure that they comply with the following:
   
   a. Award provisions;
   b. Federal policies or guidelines that regulate the award;
   c. State regulations;
   d. UAMS regulations.

5. Central Administration will arrange for regular computer printouts showing charges to an award account and monthly payroll certification forms. Arrangements will also be made for the preparation of the final financial report and other closing documents that are required by an award. The principal investigator/project director will be responsible for the preparation of the technical report.

6. Contact the Office of Research Administration at extension 65502 for assistance and additional information.

REFERENCE

Research Administration Guide
Grants and contracts for research at the University of Arkansas for Medical Sciences are awarded to the Board of Trustees of the University of Arkansas. The University is responsible for the administration of the projects. Administrative authority may be delegated through the dean to the chairman of the department in which the principal investigator is located. With a view toward successful operation of the project, Office of Research Administration personnel, extension 65502, will assist the departments and the principal investigators in fulfilling grant and contract requirements by serving, when requested, in a liaison capacity between principal investigators and the University's staff or service offices. Controller's Office personnel, extension 66843, will address questions specifically related to grant and contract accounting and/or payroll matters.

PROCEDURE

1. The principal investigator serves as the University's grant and contract agent. The responsibilities of the principal investigator include the technical requirements and the day-to-day administration of the sponsored award.
2. Specific responsibilities of the principal investigator may be found in Appendix J of the Research Administration Guide.
3. Contact the Office of Research Administration at extension 65502 for assistance and additional information.
The overall objective of ARIA is to provide an integrated environment for the exchange of information from ORSP, IRB, Office for Clinical Trials, Animals, Biosafety, and Laboratory for UAMS campus-wide research. ARIA is designed to be a major component of a comprehensive solution for the information technology needs of administrators, researchers, and institutions while maintaining an emphasis on compliance with regulatory requirements. Through implementation of ARIA, researchers will be provided a supporting infrastructure to continue their mission to engage in activities that improve the health and well-being of people and animals.

ARIA is supported in part by the National Center for Research Resources of the National Institutes of Health.
Welcome to the General Clinical Research Center!

Supported by the National Institutes of Health's (NIH) National Center for Research Resources, the GCRC includes a six-bed inpatient facility and an outpatient clinic accommodating approximately 3,500 visits annually. The bionutrition component of the GCRC can provide constant metabolic diets and nutritional counseling. The on-site core lab can accommodate specimen handling and routing tests. The nursing staff includes six research nurses, cross trained in both pediatric and adult care. Investigators requiring data and safety monitoring boards, statistical development and analysis, and database design and storage are supported by enthusiastic, knowledgeable GCRC professionals.

The GCRC provides a safe, welcoming environment for the comfort of principal investigators and study subjects alike. A variety of room configurations allow flexibility in the way studies are conducted.

Who is eligible to participate? All UAMS faculty are encouraged to use the GCRC services. Currently active researchers include those from the Colleges of Medicine, Pharmacy, and Nursing, as well as from the VA Hospitals and Arkansas Children's Hospital.

The GCRC Mission

The primary purpose of the GCRC is to provide clinical research infrastructure to investigators in human-based research who are funded by the NIH or by federal, state, and local agencies and the private sector. The Center provides space, staff and other resources to further translational research in Arkansas and acts as a catalyst for collaboration among basic and clinical scientists.

The Center serves as an institutional resource for new clinical investigators to complete pilot studies that may result in extramural funding. The GCRC also provides educational programs and grants in support of new investigators.
Welcome to the Office for Clinical Trials

The Office for Clinical Trials (OCT) represents a joint effort by the University of Arkansas for Medical Sciences (UAMS), the Central Arkansas Veteran’s Healthcare System (CAVHS), and the Arkansas Children’s Hospital Research Institute (ACHRI) to create an environment in which industry-supported clinical research involving new drugs, devices, and biologics will be conducted in an ethical and efficient manner by highly-trained, qualified investigators and clinical research coordinators in accordance with appropriate federal and state laws, regulations, and guidelines, as well as local IRB policies.

Contact Information:
Office for Clinical Trials
4301 West Markham, Mail Slot 718-3
Little Rock, AR 72205-7199

Coordinator: Julia Washam RN, CDE, CCRC
Telephone: 501-686-8572
Fax: 501-526-7465
Email: washamjuliak@uams.edu

Director: Tom Wells MD, MBA
Telephone: 501-603-1638
Fax: 501-526-7465
Email: wellsthomasg@uams.edu

University of Arkansas for Medical Sciences
4301 W. Markham St., Mail Slot 718-3, Little Rock, AR 72205

Questions about this page? Send us an E-mail.
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Office of Grants and Scientific Publications

Who we serve
Most investigators are not charged for OGSP services. OGSP is funded through contracts and fee-for-service payments. Currently, OGSP supports investigators at UAMS through annual contracts with the Arkansas Cancer Research Center, College of Medicine, College of Public Health, Arkansas Center for Health Improvement, Myeloma Institute for Research and Therapy, and several departments.

OGSP works with administrators of each contracting organization to approve the use of time for various projects. Investigators whose projects fall under existing contracts are not charged for services. Projects that are not supported through existing contracts can be accepted on a fee-for-service basis.

Services Offered

Grant proposals
- Assist with project management and scheduling
- Create electronic templates according to funding agency guidelines
- Edit research plans for style, grammar, content, and adherence to guidelines
- Collect information for forms and create documents
- Assist investigators with budget development, preparation, and justification
- Electronically format all text and forms
- Work with Office of Research and Sponsored Programs and departments on internal documentation and sign-offs
- Manage final printing and submission process after editing and form preparation is complete, including hard copy and electronic submissions

Manuscripts and other documents
- Consult with authors regarding manuscript organization and data presentation
- Assist in editing manuscripts for specified peer-reviewed journals and books or other reports
- Help with electronic submission

Other Services
- Provide available NIH biographical sketches and other support documentation
- Make electronic PHS 398 forms available in Word format
- Conduct seminars on grantsmanship and abstract/manuscript writing skills

How to obtain services
Requests for assistance are evaluated and prioritized by the Director of OGSP and institutional leaders on the basis of scientific merit, institutional priority, and funding or publication potential.
To receive assistance, schedule a meeting with the OGSP Director or Assistant Director to discuss needed services and deadlines. Please note that several weeks’ or months’ notice may be required for scheduling large, multidisciplinary projects, especially for standard NIH deadlines.

Phone: 501.686.6004  
Fax: 501.526.6770  
Office: ACRC, Trailer #4  
Mail: UAMS  
4301 West Markham, # 752  
Little Rock, AR 72205

**Scheduling priorities**  
Priorities for all OGSP projects are established based on the following principles.

- **Basic priorities**—Grant proposals take priority over manuscripts for peer-reviewed publications.
- **Types of grants**—Center grants will have priority over individual investigator’s applications.
- **Advance scheduling**—Projects that are scheduled well in advance of the submission deadline will have priority over requests made only a short time before the deadline.
- **Multiple projects from one PI**—To ensure that a variety of investigators receive support, investigators requesting assistance for more than 1 application within a 2-week time frame will be asked to prioritize their projects. The highest priority project will be scheduled in accordance with OGSP policies. The other project(s) will be placed on a “waiting list.” If OGSP can help the investigator without turning away other investigators, then the project(s) on the waiting list will be added to the schedule when resources are available.
- **Other priorities**—When projects compete for limited time, high-priority projects from groups with a service agreement will take precedence over either low-priority projects from groups with service agreements or fee-for-service projects.
- **Selection of projects**—When multiple high-priority projects have the same deadline and staffing levels are not sufficient to complete all projects, the OGSP Advisory Committee will determine which projects will be completed.

**Administrative structure**  
OGSP is an administrative component of the Arkansas Cancer Research Center and also reports to the Dean of the UAMS College of Medicine. It is guided by an Advisory Committee, which is composed of the following members or their representatives:

- Dean, College of Medicine (COM)  
- Director, Arkansas Cancer Research Center (ACRC)  
- Director, Arkansas Center for Health Improvement (ACHI)  
- Dean, College of Public Health (COPH)  
- Director, Grants & Scientific Publications (non-voting member)

The Advisory Committee meets as needed to accomplish the following tasks:

- Set overall goals and mission for the office  
- Determine what projects will receive priority when more than one project competes for services during a specific time period  
- Approve annual budget and fee structure for services  
- Approve expansion of office in terms of personnel or services  
- Ensure continued operation of the office by providing a base of financial support, space, and oversight
The UAMS Office of Research and Sponsored Programs (ORSP) is the facilitator of the pre-award grants, contracts, subcontracts and industry-sponsored agreements process. Funding is often contingent on approval of research protocols overseen by the UAMS Institutional Review Board, a division of ORSP. The office also works with persons engaged in non-research projects and programs -- functions such as outreach programs, training and fellowships -- which have an equally important impact on funding within the medical community at UAMS. In addition, the office serves as a conduit of information on grant programs, sponsored programs, the latest funding and research news, medical fellowships, and governmental and non-governmental agencies.

Note: Retroactive to October 1, 2005, use through ARIA of the on-line Proposal Review Form, or "Blue Sheet," has become mandatory. If a login and password for the Projects module of ARIA is needed, please contact Connie (Hendrixson) Price at 526-5494 or Veda Leopard at 686-5502. If IRB protocols have been submitted through ARIA, the current account will be used. However, Ms. Price or Ms. Leopard must be contacted prior to submission of grant proposals through the Projects module of ARIA. Please contact ORSP for any required training, which will be offered in both a classroom setting and in one-on-one sessions. A class schedule will be available soon. To schedule individual sessions, please contact Ms. Price.

All grant-proposal paperwork, including the on-line Blue Sheet, must be submitted to ORSP at least 24 hours before the scheduled deadline.

ORSP is located in the Biomedical Research Center, Building One, Room 102. Operational hours are 8 a.m.-5 p.m. Monday through Friday. The office is closed during UAMS holidays.

ADDITIONAL LINKS
Grant Submission Deadlines for Major Extramural Funding Sources
Grant Submission Deadlines for UAMS Intramural Funding Sources
Submitting Information About New Grants and Honors (UAMS College of Medicine)

National Institutes of Health

- Initial Plans for Transition from PHS398 to New Electronic SF424 (R&R) for Grant Proposal Submissions
- eRA Commons
- Grant and Funding Sources, Writing Grant Proposals
- Monthly List of Grants and Awards at UAMS, Other Arkansas Institutions: FY 2005
- NIH Roadmap: Funding Opportunities and Deadlines
- Pending Progress Reports
Office of Research and Sponsored Programs, UAMS
4301 W. Markham St., Little Rock, AR 72205
ORSP Phone: (501) 686-5502
ORSP Fax: (501) 686-8359
IRB Hotline: (501) 526-7134
HIPAA Privacy Research Hotline: (501) 526-7135

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UAMS Institutional Review Board (IRB)

The IRB is currently a division of the UAMS Office of Research and Sponsored Programs.

Protecting the rights and welfare of research subjects is the sole purpose of the Institutional Review Board (IRB) at UAMS. The IRB committee -- which comprises healthcare providers from a variety of disciplines and lay representatives from the at-large community -- has the authority to approve, disapprove, or require modifications of research activities that fall within its jurisdiction. In addition, the IRB may work in conjunction with other university or institutional committees; however, it reviews research projects independently based upon the principle that human participants will be adequately protected.

All research projects involving human subjects must be submitted to the committee through use of the IRB forms prior to initiation of the research. Principal investigators submitting to the IRB should refer to the New IRB Investigator’s Handbook (2005 -- Version 3, Revised 9-22-2005) for specific guidelines on conduct of human research studies.

IRB REVIEW FEES

<table>
<thead>
<tr>
<th>Category</th>
<th>New Submission</th>
<th>Continuing Review</th>
<th>Payment Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Industry Funded</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Industry-Sponsored (FDA-ICH regulated)</td>
<td>$1,750</td>
<td>$600</td>
<td>Contract/Study Acct.</td>
</tr>
<tr>
<td>b. Industry-Supported</td>
<td>$500</td>
<td>$200</td>
<td>Contract/Study Acct.</td>
</tr>
<tr>
<td>c. Drug/Device Provided without funding support</td>
<td>$200</td>
<td>$100</td>
<td>Investigator</td>
</tr>
<tr>
<td>II. Non-federal grants, awards, gifts with no indirect (e.g., foundations, tobacco settlement)</td>
<td>$250</td>
<td>$100</td>
<td>Grant</td>
</tr>
<tr>
<td>III. No funding or departmental funds (includes CUMG)</td>
<td>$50</td>
<td>$30</td>
<td>Investigator</td>
</tr>
<tr>
<td>IV. Other (Specify) (e.g., multiple funding sources)</td>
<td>Negotiable</td>
<td>Negotiable</td>
<td></td>
</tr>
</tbody>
</table>

The IRB serves the following institutions:

- University of Arkansas for Medical Sciences (UAMS)
- Arkansas Children’s Hospital (ACH)
- Arkansas Children's Hospital Research Institute (ACHRI)
- Arkansas Department of Health and Human Services (DHHS)
- Central Arkansas Veterans Healthcare System (CAVHS)
Do you have general questions, concerns, complaints or suggestions about being a current or potential research participant? If so, please call the Institutional Review Board office at **(501) 686-5667**.

**Institutional Review Board, UAMS**
4301 W. Markham St., Little Rock, AR 72205

IRB Fax: **(501) 686-7265**
IRB Hotline: **(501) 526-7134**
HIPAA Research Privacy Hotline: **(501) 526-7135**

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This Investigators Handbook has been provided by the University of Arkansas for Medical Sciences Institutional Review Board and the UAMS Office of Research Compliance to assist researchers in preparing their application for review of research involving human subjects in accordance with the guidelines set forth by the University.

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With this handbook, we are instituting a new system of indicating handbook editions. The new method will consist of the year, followed by a version number and a revision date. For example, the first handbook is the 2004 – Version 1 – Revised 08/31/2004 edition.

Archived Handbook versions can be found at the link http://www.uams.edu/orc/Links/Handbooks.htm.

************************************************************************************************

The 2004 – Version 2 – Revised 09/09/2004 edition was created to correct minor typographical errors and linking problems with the first edition. Changes were made to only formatting issues, not content.

************************************************************************************************


NOTE: The following page numbers represent the internal document (Investigator’s Handbook), not the Adobe page numbering system:

Page 3 – UAMS IRB Meeting Schedule and Submission Deadlines
Added last sentence in first paragraph regarding official UAMS holidays.

Page 35 – IRB Protocol Submissions Requirements Using ARIA
Removed reference to Appendix I and added link to Chapter 5 – Informed Consent and the Investigator’s Checklist for Informed Consent on the IRB website.

Page 83 – Non-English-Speaking Subjects
Added link to IRB Policy 15.4, Non-English-Speaking Research Subjects.

Page 115 – University of Arkansas for Medical Sciences (UAMS) website
Corrected link to the IRB website.

************************************************************************************************


NOTE: The following page number represents the internal document (Investigator’s Handbook), not the Adobe page numbering system:

Page 99 – ORC Information
Revised information including the purpose and duties of the staff of the Office of Research Compliance.

CHAPTER 1 – THE IRB AT THE UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES

Page 4 - UAMS IRB Executive Committee
Added three paragraphs in a new section titled “UAMS IRB Executive Committee” and a link to the new IRB Policy 1.7 (Executive Committee).

CHAPTER 2 – WHAT IS SUBJECT TO IRB REVIEW?

Page 6 – Studies Requiring Review
Added five paragraphs in a new section titled “Studies Requiring Review”. This section includes information about research activities and a link to revised IRB Policy 1.4 (Studies Requiring Review).

CHAPTER 3 – IRB REVIEW REQUIREMENTS

Pages 15-19 – Exempt Review
Added new information regarding Exempt Review and link to IRB Policy 7.3 (Exempt Categories of Research).

Pages 19-25 – Expedited Review
Added new information regarding Expedited Review and link to IRB Policy 7.5 (Expedited Review).

Page 28
Moved Guidelines for Blood Draws in Pediatric and Adult Populations to end of Chapter 3.

CHAPTER 4 – PROTOCOL SUBMISSIONS

Page 30 – Investigator Requirements
Added information detailing the requirements for investigators and a link to IRB Policy 7.2 (Investigator Qualifications).

Page 31 – Study Closure
Revised information to state that the final report of study results should be received by the IRB within 30 days of decision to close a study.

Page 36 – Approval Bodies and Committees
Added information regarding working with committees and departments at UAMS, CAVHS, ACH, and ACHRI and a link to IRB Policy 2.2 (To Other University or Affiliated Committees/Departments).

Pages 36 and 37 – Other IRBs
Added information regarding working with other IRBs; added a link to IRB Policy 2.3 (To Other Institutions); and added information regarding the number and composition of IRB committees.
CHAPTER 4 – PROTOCOL SUBMISSIONS (continued)

Page 39 – Added information about Institutional Biosafety Committee.

Page 40 – Added information about Conflicts of Interest Committee.

Page 42 – Data Safety Monitoring Information
Added new section regarding Data Safety Monitoring requirements.

CHAPTER 5 – INFORMED CONSENT

Page 51
Changed name of section from “Informed Consent Requirements” to “Informed Consent Document Elements”

Page 52
Added new section called “Informed Consent Document Elements Information”, added information detailing that the IRB has the ability to waive all or a part of the informed consent requirements, and added link to IRB Policy 15.3 (Waivers of Signed Informed Consent Documents and Waivers of Informed Consent Elements).

Page 52
Added link to IRB Policy 15.1 (Informed Consent).

CHAPTER 6 – CONTINUING REVIEW

Pages 57 and 58
Revised the information concerning the items an investigator must provide for continuing review, including adding item number x. (Reports from Data Safety Monitoring…), and added a link to IRB Policy 7.6 (Continuing Review).

CHAPTER 8 – RESEARCH RECORD-KEEPING AND REPORTING

Page 67
Added information concerning a change in Principal Investigator (PI).

Pages 68 and 69
Added information about Unanticipated Problems time frame in chart and a link to new IRB Policy 10.3 (Principal Investigator IRB General Reporting Requirements).

Page 70
Added information about reporting a death or Serious Adverse Event (AE).
CHAPTER 8 – RESEARCH RECORD-KEEPING AND REPORTING (continued)

Pages 72
Added new section and link to IRB Policy 2.6 (Reporting To Appropriate Federal Oversight Bodies, Institutional Officials And Research Sponsors).

Page 72
Added new section (Changing Study Protocol/Modifications to Previously Approved Research).

CHAPTER 9 – EMERGENCY SITUATIONS

Pages 74-76
Added revised information regarding IRB Policy 18.3 (Emergency Use of A Drug or Biologic).

Pages 76-78
Added revised information regarding IRB Policy 18.4 (Emergency Use of an Unapproved Medical Device).

CHAPTER 11 – INVESTIGATIONAL DRUGS AND MEDICAL DEVICES

Page 83
Added links to IRB Policies 7.3 (Exempt Categories of Research) and 7.5 (Expeditied Review) in the Using Investigational New Drugs section.

Pages 85-86
Added new section (Sponsor-Investigator’s Responsibilities Related To Investigational New Drugs)

CHAPTER 12 – RESEARCH INVOLVING VULNERABLE POPULATIONS

Page 90
Added new information regarding research involving children.

Pages 90-91
Revised definition of children in the state of Arkansas.

Pages 91-93
In the Categories of Research Involving Children, changed the word “subjects” to “participants” and revised Pediatric Risk Categories I – IV.

Page 95
Added new information regarding Prisoners in Research

Page 98
Added link to revised IRB Policy 17.2 (Cognitively Impaired Persons).
CHAPTER 12 – RESEARCH INVOLVING VULNERABLE POPULATIONS (continued)

Page 99
Added new section, Legally Authorized Representative (LARS) and link to new IRB Policy 17.13 (Legally Authorized Representatives).

Page 102
Added new section, Research in Nursing Homes, and link to revised IRB Policy 17.4 (Subjects in Long Term Care).

CHAPTER 13 – PAYMENT/REIMBURSEMENT OF RESEARCH SUBJECTS

Pages 104-105
Deleted section “Payments to Subjects” and added new section “Subject Compensation”

Pages 105-106
Added new section “Recruitment of Study Subjects”

CHAPTER 15 – IRB AUTHORITY IN NON-COMPLIANCE ISSUES

Pages 111-112
Added two new paragraphs regarding non-compliance at the end of the Non-Compliance Issues section.

Page 112
Revised information regarding the time frame to submit the final report of study results during a study closure.

CHAPTER 19 – GLOSSARY

Pages 124-139

Deleted 1 glossary item:
Investigator/Sponsor

Revised 7 glossary items:
- Assent
- Human Subject
- In Vitro Fertilization
- Pregnancy
- Research
- Sponsor
- Standard Operating Procedures (SOPs)
Added 64 new glossary items:

- Adult Risk
- Adult Minimal Risk
- Approved
- Approved With Major Revisions
- Approved With Minor Revisions
- Clinical Investigation
- Consumer Preference Testing
- Continuing Non-Compliance
- Current Good Manufacturing Practices (Cgmp)
- Current Good Tissue Practices (Cgtp)
- Data And Safety Monitor
- Data And Safety Monitoring Board (Dsmb)
- Data Safety Monitoring Plan (Dsmp)
- Dead Fetus
- Declined
- Expired Studies
- Fda Acknowledgment Letter
- Federal Oversight Body
- Fetus
- Food And Drug Administration (Fda)
- Funding Source
- Good Clinical Practices (Gcp)
- Human Subject Research
- Imminent Threat Of An Ae In Research
- Ind Monitoring Plan
- Irb Authorization Agreement
- Irb Of Record
- Interaction
- Intervention
- Investigational Agents
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- Investigational Drugs/Investigational Biologics
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- Investigational New Drug (Ind)
- Legally Authorized Representative (Lar)
- Non-Compliance
- Non-Human Subject Research
- Non-Significant Risk (Nsr) Device Study
- Nonviable Fetus
CHAPTER 19 – GLOSSARY (continued)

Added The Following New Glossary Items:

- Pediatric Risk Category I
- Pediatric Risk Category II
- Pediatric Risk Category III
- Pediatric Risk Category IV
- Private Information
- Related Event
- Scientific Misconduct
- Serious Adverse Event
- Serious Event
- Serious Non-Compliance
- Significant Risk (Sr) Device Study
- Sponsor/Investigator
- Substantive Action By The Irb
- Suspended For Cause
- Tabled
- Terminated For Cause
- Test Article
- Treatment Ide
- Unanticipated Adverse Device Effect
- Unanticipated Event
- Unanticipated Problem Involving Risks To Participants Or Others
- Unanticipated Adverse Event
- Unexpected Event
- Viable
- Waiver
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<td>3</td>
<td>3</td>
<td>The Membership and Structure of the UAMS IRB</td>
<td>Added information that two VA members appointed by CAVHS are members of the UAMS IRB.</td>
</tr>
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<td>3</td>
<td>3</td>
<td>UAMS IRB Meeting Schedule and Submission Deadlines</td>
<td>Added information that meetings are usually held on the first four Tuesdays of each month and that deadline adjustments can be made at the discretion of the IRB Chair.</td>
</tr>
<tr>
<td>4</td>
<td>4</td>
<td>UAME IRB Executive Committee</td>
<td>Deleted the information regarding the Assistant Vice Chancellor for Research will serve as Chair of the Executive Committee and added the information that Legal Counsel and a representative from the CAVHS Research and Development committee are ad hoc ex-officio members of the Executive Committee.</td>
</tr>
<tr>
<td>6</td>
<td>6</td>
<td>Scope of IRB Review</td>
<td>Deleted the Arkansas Department of Health (ADH) from the list of institutions requiring IRB review and approval.</td>
</tr>
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<td>7</td>
<td>7</td>
<td>Research Review Requirements</td>
<td>Revised the definition of clinical investigations as any experiment that involves the use of an FDA regulated product.</td>
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<td>Revised the information in the example text box.</td>
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<td>Deleted the last bullet item.“Is the proposed activity intended to fulfill requirements fulfill requirements for a master’s thesis, doctoral dissertation, or other research requirement?”</td>
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## Changes from Version 1 to Version 2

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<td>8</td>
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<td><strong>Research Conducted By Students and Residents</strong></td>
<td>Revised the 4th bullet number to read “Establish and maintain strict guidelines for protecting privacy and confidentiality” by replacing the word anonymity with privacy.</td>
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<td>12</td>
<td>12</td>
<td><strong>When is IRB Review Required?</strong></td>
<td>Deleted the citation 45CFR from the list of federal regulations.</td>
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<td>15</td>
<td>15</td>
<td><strong>Type of IRB Review For New Protocols</strong></td>
<td>In the three categories of review chart, under the heading Exempt Review; the first sentence was revised to read “Some research falls into a category of research called exempt.”</td>
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<td>15-19</td>
<td>15-19</td>
<td><strong>Exempt Review</strong></td>
<td>Changed all references from IRB Chair to IRB Chair/Desiginee</td>
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<td>16</td>
<td>16</td>
<td><strong>Categories of Exemption (Per 45 CFR 46.101)</strong></td>
<td>Deleted “From IRB Review” from section title.</td>
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<tr>
<td>19</td>
<td>20</td>
<td><strong>Expedited Review (Per 45 CFR 46.110)</strong></td>
<td>Deleted the following sentence from the first paragraph “Decisions reached at the convened meetings may supercede any decisions made through the expedited review.”</td>
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<td>20</td>
<td>20</td>
<td><strong>For a new protocol to qualify for Expedited Review, the research must:</strong></td>
<td>Added the sentence “For a new protocol to qualify for Expedited Review, the research must:”</td>
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Revised the wording in items 2-4.
### Categories of Expedited Review for New Protocols

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| 20-23           | 20-23           | **Categories of Expedited Review for New Protocols** | Deleted items 8 and 9 and changed the section heading as “Continuing review of research by the expedited procedure must meet one of the following criteria:”  
Added numbers 1-5  
Revised the paragraph regarding modifications.  
Changed “Procedure” to “Investigator Procedure”. |
| 23-24           | 23-24           | **Investigator Procedure**                         | Changed item #1 to “For Initial Review of an Expedited Protocol, Investigator must:”  
Revised items 1.1, 2, 2.1, 3, and 3.1. |
| 24-25           | 24              | **IRB Procedure**                                 | Renamed section heading “IRB Procedure”  
Changed item #1 to “For Initial Review of an Expedited Protocol, IRB Chair/Designee must:”  
Revised items 1.1, 1.2, 1.3, 1.4, 1.5, 1.6, 2, 3, and 3.1.  
Deleted last two sections. |

**Expedited Review May Not Be Appropriated In The Following Situations:**

**Expedited Review Process For Minor Changes In Research**
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<td>25</td>
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<td>25</td>
<td></td>
<td>Revised “Protocol Tabled:”</td>
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<td>26</td>
<td>25</td>
<td></td>
<td>Revised “Protocol Declined:”</td>
</tr>
<tr>
<td>26</td>
<td>30</td>
<td></td>
<td>Deleted “Protocol Disapproved:”</td>
</tr>
<tr>
<td>30</td>
<td>30</td>
<td><strong>Definition of Research</strong></td>
<td>Revised the definition of research.</td>
</tr>
<tr>
<td>31</td>
<td>30-31</td>
<td><strong>Responsibilities Of The Principal Investigator When Submitting A Study For IRB Approval</strong></td>
<td>Revised 2nd paragraph regarding CRR.</td>
</tr>
<tr>
<td>31</td>
<td>31</td>
<td><strong>Study Closure Information</strong></td>
<td>Revised last sentence to read “Studies are not to be closed until the Investigator has determined that the study no longer needs access to any identifiable information.”</td>
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<td>31-32</td>
<td>31-32</td>
<td>The PI is responsible for abiding by the Investigator’s Agreement that includes the following items:</td>
<td>Deleted bullet #4 “Any unexpected serious problem, such as:…”</td>
</tr>
<tr>
<td>34</td>
<td>34</td>
<td>Specifying the Number of Research Subjects</td>
<td>Deleted the 2\textsuperscript{nd} paragraph “Enrolled Subjects are subjects are defined as those who met eligibility criteria and gave informed consent to participate in the larger study.”</td>
</tr>
<tr>
<td>36</td>
<td>36</td>
<td>Approval Bodies and Committees</td>
<td>Deleted the last sentence in the 1\textsuperscript{st} paragraph “If gaining institutional committee letters cause a significant delay, the Investigator may submit copies of his letters requesting approval with the submission to the IRB.”</td>
</tr>
<tr>
<td>36-37</td>
<td>36</td>
<td>Other IRBs</td>
<td>Deleted the last part of the first sentence, “OR the UAMS IRB must have a monitoring plan for the other IRB.”</td>
</tr>
<tr>
<td>39</td>
<td>39</td>
<td>VA R &amp; D Committee</td>
<td>Revised the first paragraph by deleting item # (1) Principal Investigator receives any salary from the VA.</td>
</tr>
<tr>
<td>42</td>
<td>42</td>
<td>Data Safety Monitoring Information</td>
<td>Revised first paragraph.</td>
</tr>
<tr>
<td>43</td>
<td>43</td>
<td>Application Forms and Original Signatures</td>
<td>Deleted the second sentence in the text box “The IRB must approve the alternate or formally authorized signatory.”</td>
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<tr>
<td>44</td>
<td>43-44</td>
<td>Information From The Following Documents Is Needed For Protocol Submissions Via ARIA:</td>
<td>Added the following sentence to 2\textsuperscript{nd} bullet regarding the consent form “If a DHHS approved sample consent exists, provide it as well and justification for any substantial deviations.”</td>
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<td>45-49</td>
<td>45</td>
<td><strong>How To Submit A New Study Protocol Using ARIA</strong></td>
<td>Revised the instructions by deleting the sections “How To Submit A New Behavioral Study Protocol Using ARIA” and “How To Submit A New Biomedical Study Protocol Using ARIA” and renaming the section “How To Submit A New Study Protocol Using ARIA”.</td>
</tr>
<tr>
<td>54</td>
<td>50</td>
<td><strong>Exceptions From The Standard Informed Consent Procedures</strong></td>
<td>Deleted the section “Obtaining Informed Consent in Emergency or Compassionate Situations”</td>
</tr>
<tr>
<td>55</td>
<td>51</td>
<td><strong>Waiver of the Requirement to Obtain Prospective Informed Consent From Subjects in Non-Emergency Research</strong></td>
<td>Deleted the last sentence in the 2nd paragraph “Consent waivers will be discussed during a meeting of the convened IRB.”</td>
</tr>
<tr>
<td>57</td>
<td>53</td>
<td><strong>Continuing Review General Information</strong></td>
<td>Revised information to say that Continuing Review must occur at least once per year instead of every 365 days.</td>
</tr>
<tr>
<td>57</td>
<td>53-43</td>
<td><strong>IRB Continuing Review Requirements Using ARIA</strong></td>
<td>Deleted the 4th paragraph “Each PI needs a username and password to access the ARIA system. For assistance with obtaining an ARIA username and password, please contact the IRB office at 501-686-5667.”</td>
</tr>
<tr>
<td>58</td>
<td>54</td>
<td><strong>IRB Continuing Review Process</strong></td>
<td>Revised the information from “Federal regulation require IRB Continuing Review approval every 365 days” to “at least once per year.”</td>
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<tr>
<td>58-60</td>
<td>54-56</td>
<td><strong>IRB Continuing Review Process</strong></td>
<td>Following the sentence “Protocols more likely to be reviewed at least every six months include:” deleted the bullet items and replaced them with items a-h. Deleted the bullet items regarding a status report and changed it to a Continuing Review Report.</td>
</tr>
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<td>59</td>
<td>56</td>
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<td>59-60</td>
<td>56</td>
<td><strong>Continuing Review Ruling are as follows:</strong></td>
<td>Changed Protocol Re-approval to Protocol approval. Changed Protocol Re-approval Deferred (Major or Minor) to Protocol approval Deferred (Major or Minor) and also revised the last sentence to read “This information must be received as requested by the IRB,” by deleting “or the study may be out of compliance and the Investigator must stop enrollment.”</td>
</tr>
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<td>60</td>
<td>56</td>
<td><strong>Important Reminders</strong></td>
<td>Revisited the last paragraph to read “All protocols not approved by the IRB by the project’s continuing review expiration date are no longer approved. All new accrual must cease and all further subject (or data) interactions must cease unless specifically approved by the IRB due to subject safety concerns.”</td>
</tr>
<tr>
<td>61</td>
<td>57</td>
<td><strong>Continuing Review Summary Information</strong></td>
<td>Deleted last paragraph.</td>
</tr>
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<td>63</td>
<td>69</td>
<td><strong>Protocol Amendments</strong></td>
<td>Changed “patient” to “participant” in 1st sentence in the 2nd paragraph.</td>
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<td>65</td>
<td>61</td>
<td><strong>ARIA Information</strong></td>
<td>Changed “All Serious Adverse Event (SAE) reporting” to “All reporting” in 1st sentence.</td>
</tr>
<tr>
<td>65-66</td>
<td>61-62</td>
<td><strong>Record-Keeping Responsibilities Of The Principal Investigator</strong></td>
<td>“Reports of unanticipated problems involving risks to participants or others” replaced “Reports of deaths, protocol violations, protocol deviations and serious adverse events” in the text box.</td>
</tr>
<tr>
<td>68-69</td>
<td>64-65</td>
<td><strong>Reporting Responsibilities Of The Principal Investigator To The IRB</strong></td>
<td>Revised information in the “Investigator Must Report” and “Time Frame for Reporting” columns.</td>
</tr>
<tr>
<td>69-70</td>
<td>65-66</td>
<td><strong>Adverse Event Reporting</strong></td>
<td>Revised information in this section.</td>
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<td>71</td>
<td>67</td>
<td><strong>Reporting Notification Of Pending Audits Or Inquiries</strong></td>
<td>Revised information in this section.</td>
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<td>90</td>
<td>86</td>
<td><strong>Background Information</strong></td>
<td>Removed “Veterans” from the list of Other Potentially Vulnerable Populations.</td>
</tr>
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<td>113</td>
<td>109-110</td>
<td><strong>Suspension</strong></td>
<td>Revised section by removing bullet item #9.</td>
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CHAPTER 1

The IRB At The University of Arkansas For Medical Sciences

Protecting human subjects involved in research is a collaborative effort that demands the vigilance of UAMS faculty, staff, and students in partnership with the local community, federal agencies and agencies sponsoring research. This guide is intended to help researchers meet their responsibilities.

The Purpose of the University of Arkansas for Medical Sciences Institutional Review Board

Authority and Responsibility of the UAMS IRB

The membership and structure of the UAMS IRB

UAMS IRB Meeting Schedule and Submission Deadlines

UAMS IRB Executive Committee
The Purpose Of The University Of Arkansas For Medical Sciences Institutional Review Board

The purposes of the University of Arkansas for Medical Sciences (UAMS) Institutional Review Board (IRB) are:

- To protect the rights and welfare of human research subjects.
- To approve the initiation of and conduct periodic reviews of biomedical and behavioral research involving human subjects.
- To terminate or suspend studies in human subjects.

The UAMS Institutional Review Board (IRB) is the deliberative body designated by the following institutions, among others:

- University of Arkansas for Medical Sciences (UAMS)
- Arkansas Children’s Hospital/Arkansas Children’s Hospital Research Institute (ACH/ACHRI)
- Central Arkansas Veteran’s Healthcare System (CAVHS)
- Arkansas Department of Health (ADH)

This committee operates according to Federal, State, Institutional and Good Clinical Practices (GCP) guidelines. The UAMS IRB also recognizes the tripartite International Code of Harmonization (ICH).

The UAMS IRB has the authority to approve, disapprove or require modifications of research activities that fall within its jurisdiction. The UAMS IRB may work in conjunction with other university or institutional committees; however, it reviews research projects independently based upon the principle that human participants will be adequately protected.

Authority and Responsibility of the UAMS IRB

The UAMS IRB operates under a Federalwide Assurance (FWA). This is an agreement between the UAMS IRB and the Department of Health and Human Services (DHHS), which outlines the responsibilities of the UAMS IRB for upholding the ethical principles regarding research involving human subjects. These principles are outlined in the report of the National Commission for the Protection of Human Subjects in Biomedical and Behavioral Research titled, Ethical Principles and Guidelines for the Protection of Human Subjects of Research (known as the “Belmont Report”).

The Office for Human Research Protections (OHRP) oversees research activities for DHHS. The Office of Research Oversight (ORO), formerly the Office for Research Compliance and Assurance (ORCA) also oversees studies involving veterans. Other agencies that the IRB report to include: The Food and Drug Administration (FDA), The Office of Research Integrity (ORI), institutional officials, sponsors, and funding agencies.

Normally, the IRB will agree to serve as the institutional review board for other institutions only if a staff member or faculty appointee of UAMS is involved as a Principal or Sub-
Investigator. However, the IRB will serve any state agency for a specific protocol by written request. Many ACH, CAVHS, ADH, NCTR, and ASH scientists have academic appointments at UAMS and in general will utilize or collaborate with clinical faculty of UAMS for their human studies. Appropriate agreements between the committee and the requesting institution will be required.

**The Membership and structure of the UAMS IRB**

The Vice Chancellor for Academic Affairs and Research Administration (VCAA/RA) at UAMS appoints members of the IRB, including the Chair. Appointments are generally for four-year periods. Federal requirements mandate that the IRB must have at least five members of varying backgrounds to promote complete and adequate review of research activities commonly conducted at this institution. IRB members must be knowledgeable about institutional commitments and regulations, applicable laws, standards of professional conduct, and practice. The IRB membership must be diverse in matters of race, gender, and cultural background; and include at least one person in each of the following categories:

- The member's primary concern is the scientific area
- The member's primary concern is the non-scientific areas
- The member is not affiliated with the institution and is not an immediate family member or a person who is affiliated with the institution.
- In order to review studies at CAVHS, two VA members appointed by CAVHS
- Other representatives are present to consider protocols involving children and prisoners.

No member of the IRB may participate in the initial or continuing review of any project in which that member has a conflicting interest, except to provide information requested by the IRB. IRB members include healthcare providers from a variety of disciplines and lay representatives from the community at large.

**UAMS IRB Meeting Schedule and Submission Deadlines**

The Biomedical Institutional Review Board (IRB) typically meets on the first four Tuesdays of each month. Meetings are held at 2:00 p.m. on the UAMS campus. The deadline for submission of protocols for IRB review is 10:00 a.m. two weeks prior to the scheduled meeting. Submissions not received in the IRB office by that day and time are held over for consideration at the next meeting. Deadline adjustments can be made at the discretion of the IRB Chair. In addition, official UAMS holidays may sometimes require an adjustment in the meeting dates.

The Behavioral and Social Sciences Institutional Review Board (IRB) meets the second Thursday of each month on the UAMS campus. The Behavioral and Social Sciences IRB studies reviewed by this committee are considered medically non-invasive and include studies involving questionnaires, surveys, interviews, focus groups, etc.

Select Meeting Dates and Deadlines may be found on the [UAMS IRB website](#).
UAMS IRB Executive Committee

The Executive Committee is maintained as an active resource to identify new IRB policies and procedures necessary to ensure the efficient operation of the IRB Administrative Office and IRB Committees and to ensure compliance with the standards of human subject protections as set forth in the Belmont Report and federal, state and institutional rules and regulation. Minutes of each Executive Committee meeting will be maintained and signed by the Executive Committee Chair.

The Executive Committee consists of the Vice Chancellor for Academic Affairs and Research Administration (VCAA/RA), the Chairpersons of each IRB Committee, the Office of Research and Sponsored Programs (ORSP) Director and Associate Director, and the Office for Research Compliance (ORC) Director. Legal Counsel and a representative from the CAVHS Research and Development Committee are ad hoc ex-officio members of the Executive Committee. In addition, IRB Committee members, Investigators, or other individuals will be invited to the meetings as their presence is warranted.

For more information, see IRB Policy 1.7 (Executive Committee).
CHAPTER 2

What Is Subject To IRB Review?

The scope of the Institutional Review Board's (IRB) charge is broad. Generally, any University research that uses humans, human tissue, surveys of human subjects, human subjects' records, or in some cases human cell lines requires IRB review, irrespective of its funding source. The IRB's charge extends to research in the social and behavioral sciences as well as research in the health and biological sciences.

Scope of IRB Review
Studies Requiring Review
Research Requirements
Research Conducted By “Affiliated Faculty”
Research Projects In Which The Researcher Is A Consultant
Research Conducted By Students And Residents
Research Training
Research Conducted At Other Institutions
Research That Is Part Of Multicenter Clinical Trials
Research In Foreign Countries
IRB Review
Research Involving Secondary Use Of Data
Scope Of IRB Review

IRB review and approval is required for any research involving human subjects if a staff member or faculty appointee of University of Arkansas for Medical Sciences (UAMS), Arkansas Children’s Hospital (ACH), or Central Arkansas Veteran’s Healthcare System (CAVHS) is involved as a Principal Investigator or Sub-Investigator. However, the IRB will serve any state agency for a specific protocol by written request and once appropriate agreements are in place. IRB will review research that meets any of the following criteria:

- Research conducted or sponsored by faculty, staff, students, or employees of the respective institution.
- Research performed on the premises of UAMS and associated institutions.
- Research performed with equipment or in facilities belonging to UAMS.
- Research that involves UAMS patients, students, staff, or faculty.
- Research that involves UAMS patient data.
- Satisfies a requirement imposed by the University for a degree program or for completion of a course of study.
- Certified by a dean or department head to satisfy an obligation of a faculty appointment at the University, including clinical or adjunct appointments.

Studies Requiring Review

All activities, regardless of whether the activity requires full board review, or might qualify for one of the expedited or exempt categories, that are clearly Human Subject Research should submit a complete proposal, including protocol, to the IRB through either a New Biomedical Protocol Submission or a New Behavioral Submission in ARIA. No human Subject Research study should be initiated prior to IRB approval.

The IRB has sole authority to determine whether an activity meets the definition of Human Subject Research. Any activity that might represent Human Subject Research should be submitted to the IRB for determination.

All research activities, including those deemed Non-Human Subject Research, must be carried out in an ethical and respectful fashion in compliance with the principles of the Belmont Report, all state and local laws and institutional policies.

Research conducted by, or under the direction of, any employee, faculty, staff or student of UAMS or any entity in which the UAMS IRB is designated as the IRB of record, is governed by these policies. This includes research conducted off site or research involving the use of non-public information to identify or contact human research participants or prospective participants.

To determine if a study is a human research study, please follow the procedure in IRB Policy 1.4 (Studies Requiring Review).
**Research Review Requirements**

According to the United States Code of Federal Regulations, 45 CFR 46.102(d), *Research* means a systematic investigation, including research development, testing, and evaluation designed to develop or contribute to generalized knowledge. Examples of research activity include:

- Clinical trials
- Surveys
- Interviews
- Behavioral investigations
- Prospective or retrospective reviews of medical information
- Experiments with physiological fluids and tissue
- Demonstration or service programs.

The Food and Drug Administration (FDA) includes under the definition of reviewable research, clinical investigations defined as any experiment that involves the use of an FDA regulated product. Example: Use of an FDA approved cardiac medicine in a research project studying the medicine’s impact on the treatment of neurogenic pain would be considered a clinical investigation and be subject to IRB review.

To determine whether a proposed activity is research, apply the following criteria in conjunction with IRB Policy 1.4. If there are any questions about whether a proposed project rises to the level of human subject research, email a project description to irb@uams.edu:

- Is the proposed activity intended for release to the Scientific Community as a contribution to knowledge? For example, publication in a medical or scientific journal and/or presentation at a medical or scientific meeting.
- Does the proposed activity involve an interaction or intervention with a living person that occurs solely for the purpose of the project?
- Will the proposed activity collect identifiable, private data/information in a form that is associable with the individual?
- Is the proposed activity portrayed (explicitly or implicitly) by university students, faculty, or staff as “research” or “experimental” investigation?

If any one of the above criteria is answered “yes”, the protocol must be reviewed and approved by the IRB.

**The IRB, not the Investigator, determines if an activity is research.**
Research Conducted By “Affiliated Faculty”

Research conducted by "affiliated faculty" -- faculty members who hold clinical or adjunct appointments--is subject to the University's guidelines for research on human subjects and must be submitted for IRB review. Any research project that is conducted by or under the direction of any employee or agent of this institution, in connection with his or her institutional responsibilities, requires IRB approval.

Research Projects In Which The Researcher Is A Consultant

UAMS IRB review is required unless the researcher has a strict consulting relationship in which:

- The researcher is hired on his or her own time and does not use Institutional resources.
- The researcher holds no rights in the work.
- Neither the researcher nor the institution retains any data.

All three of these criteria must be met, or the IRB will need to review the project.

Research Conducted By Students and Residents

Independent class projects, senior theses, undergraduate research projects, master's projects, partial fulfillment of fellowship requirements, and similar exercises utilizing human research must be independently submitted to the IRB by the student/resident-researcher but a physician/faculty member ultimately is responsible for the protection of the subjects and should be listed as the Responsible Staff Person in ARIA. Advisers shoulder the responsibility for students or residents engaged in independent research, and instructors are responsible for research that is conducted as part of a course. Because students and residents are transient, the faculty member sponsor must rigorously defend why they are not the Principal Investigator for such projects.

During the design of a project, advisors and faculty members should instruct students and residents on the ethical conduct of research and help them prepare applications for IRB approval. In particular, students and residents should do the following:

- Understand the elements of informed consent.
- Develop a readable consent form written in the second person and at a level equivalent to an eighth grade education.
- Plan appropriate recruitment strategies for identifying subjects.
- Establish and maintain strict guidelines for protecting privacy and confidentiality.
- Allow sufficient time for IRB review and completion of the project during the student or resident’s matriculation.
- Obtain certificates for required Human Subject Training and HIPAA for Research.
As assurance that the University's guidelines will be followed, the adviser or instructor is required to be listed as the Responsible Staff Person in ARIA for the student's/resident's application for IRB approval and/or serve as the Principal Investigator.

After IRB approval, faculty members should take an active role in ensuring that projects are conducted in accordance with the IRB's requirements. One way to meet this responsibility is to meet periodically with students/residents to review their progress and to assist in submitting the continuing reviews required by the IRB.

△ Research Training

The Office of Research Compliance functions as the auditing and compliance body as well as the training unit for the UAMS Institutional Review Board. This office is a component of the campus' Human Research Protections Program (HRPP) and reports directly to the senior research official at UAMS, the Vice Chancellor for Academic Affairs and Research Administration (VCAA/RA).

The ORC offers both the Online Human Subject Protection Training and the Online HIPAA For Research Training courses at [http://www.uams.edu/orc/Training/Training.htm](http://www.uams.edu/orc/Training/Training.htm).

△ Research Conducted At Other Institutions

For a UAMS researcher to participate in a research project at another site, the project needs to be reviewed by the UAMS IRB as well as by the other institution's IRB. For example, a UAMS researcher engaged in research at the CAVHS must secure approval from both the UAMS IRB and the CAVHS R&D Committee.

The UAMS IRB tries to accommodate researchers who work at multiple sites by streamlining the IRB approval process. In some cases, reciprocal review and approval arrangements with the UAMS IRB relieve the Investigator of obtaining the independent approval of two IRBs. For more information, contact the IRB at irb@uams.edu.

Researchers who must submit a project to another IRB should work closely with the UAMS IRB to ensure that the appropriate agreements are in place prior to submitting to the UAMS IRB. The researcher may be asked to submit copies of the application and review of the non-UAMS IRB. Changes in protocol or consent forms required by the other IRB should be brought to the attention of the UAMS IRB.

△ Research That Is Part Of Multicenter Clinical Trials

Approval of a proposal document at the national level is not sufficient to bypass approval at the local level. Researchers who conduct multicenter clinical trials sponsored by the National Institutes of Health (NIH) or the National Cancer Institute (NCI), for example, should include protocols and consent forms approved at the national level with their applications to the UAMS IRB. Although the documents should be identified as having been approved by a national IRB, the local IRB must review the material as it would any other submission. (OHRP Report Number 93-01).

Only the local IRB is vested with the authority to review and approve projects to be conducted at a given institution familiar with the particular circumstances of its research.
setting and is able to weigh critical considerations such as state and local laws, professional and community standards, institutional policies, and the needs of different patient and subject populations.

If changes are made to documents approved by the national IRB, the Investigator must provide timely notification to the IRB. The UAMS IRB will rarely make substantive changes in the protocol or study plan and are more likely to request that the wording of a consent form be changed to reflect local standards or to include specific language required by the University.

❖ Research In Foreign Countries

Research conducted by UAMS Investigators in foreign countries remains under University purview and guidelines. While the University cannot impose its standards for written documentation on other cultures, it does not relax its standards for ethical conduct or consent process.

The Office for Human Research Protections (OHRP) can determine whether procedures described by a foreign institution afford protections that are at least equivalent to U.S. regulations [45 CFR 46 101 (h)]. Under this provision, OHRP investigates the foreign country's guidelines for human subject research, and if the foreign guidelines are found to be equivalent to U.S. regulations, the Investigator is permitted to substitute those foreign procedures.

Researchers proposing international research should allow additional time for this review process.

❖ IRB Review

In performing reviewing tasks, the IRB shall request documentation of the following:

1) That the foreign study is done under the oversight of an IRB or Ethics Board in the country of origin.

2) Subjects must have signed an IRB Ethics Board approved consent form.

3) If samples are involved,
   - ascertain if they are de-identified and when they will be destroyed.
   - that the PI will use them only for the methods in the signed consent form.

❖ Research Involving Secondary Use of Data

Projects that use data on human subjects gathered in earlier projects require IRB review.

If the data are gathered by someone who has legitimate access to the records and who gives the Investigator only "blinded" or de-identified data (so that the Investigator is unable to identify the subjects), the level of risk is lowered.
CHAPTER 3

IRB Review Requirements

This chapter defines the different types of IRB review for new protocols.

When is IRB Review Required?

Definition of Research

Definition of Human Subjects and Ethical Considerations

IRB Review Requirements

Assigning Study Risk Category and Frequency of Continuing Review Reporting

Types of IRB Review For New Protocols

- Exempt Review
- Expedited Review
- Full Review

IRB Review Results

Notification of Investigators Following Review

Notification of Institutional Officials

Guidelines for Blood Draws in Pediatric and Adult Populations
When is IRB Review Required?

All research or clinical investigations involving human subjects or data related to human subjects, and all other activities that even in part involve such research, regardless of sponsorship, must be reviewed and approved by the IRB. No intervention or interaction with human subjects or their data in research, including recruitment, may begin until the IRB has reviewed and approved the research protocol [45CFR46.101; 21CFR56.103(a)].

Definition of Research

Research is a systematic investigation, including research development, testing, and evaluation designed to develop or contribute to generalized knowledge [45CFR46.102(d)]. Examples of research activity include clinical investigations, clinical trials, surveys, interviews, behavioral investigations, retrospective reviews of medical information, experiments with blood and tissue, and demonstration or service programs.

Definition of Human Subjects and Ethical Considerations

A human subject is defined in Title 45 of the Code of Federal Regulations, Section 46.102 (f) as a living individual about whom a professional or student Investigator conducting research obtains data through intervention or interaction with the individual or collects identifiable private information. Human subjects are also defined as an individual who is or becomes a participant in research, either as a recipient of a test article or as a control. A “subject” may be a healthy human or a patient [21 CFR 56.102 (e)].

The Nuremberg Code is the first in a series of codes of ethical conduct for modern researchers. The use of human subjects for research demands that the Investigator have a working knowledge of pertinent rules and regulations. One of the strongest threads binding the many rules and regulations together is the distinction between research subject (participant) and patient. If the activity that is planned for the subject is less effective or more dangerous than standard care, it is not “ethical” for that person to become a research subject except under notable exceptions. It is the ethical obligation of the Investigator to make findings widely known and eliminate unnecessary risk to the former subject and patients.

In its review of human subject research, the IRB has jurisdiction over all aspects of research including:

- Methods of identifying potential subjects
- Methods proposed for contacting potential subjects
- Materials to recruit subjects and proposed compensation
- Pilot studies
- Proposals to use or provide stored blood, tissues, or confidential data
- Surveys and questionnaires
- The informed consent process and forms
• The protocol and summary of the research
• Any risks to subjects from the proposed research are reasonable in relationship to anticipated benefits
• Proposed changes to the research
• Unanticipated problems involving risk to the subject or others
• Continuing reviews
• Uses of investigational drugs and devices in emergencies
• Humanitarian uses of drugs and devices
• Determination of a protocol’s eligibility for waiver of full review

The submission of any study for initial review should address those issues listed above that are pertinent to the protocol.

❖ IRB Review Requirements

The IRB is required by CFR 45 46.111 to consider all of the following during its review of proposed studies and continuing reviews:

• The IRB is required to assure that the selection of subjects is equitable and should be particularly cognizant of the special problems of research involving vulnerable populations such as children, prisoners, pregnant women, mentally disabled persons or economically or educationally disadvantaged persons.

• Risks to subjects are minimized through the use of procedures consistent with sound research.

• Risks to subjects are reasonable in relation to anticipated benefits and to the knowledge that may reasonably result.

• Informed consent is correctly obtained and appropriately documented, unless meeting the criteria for a waiver.

• Subject privacy and confidentiality of the subject data is maintained.

• The research plan makes adequate provision for the monitoring of data to ensure subject safety.

❖ Assigning Study Risk Category And Frequency Of Continuing Review Reporting

The IRB committee meetings include a discussion and vote on new protocols, major modifications, and studies submitted for continuing review. New protocols are assigned categories of risk and frequency of continuing review. In order to approve research, the IRB must determine the degree of risk.
Below is the definition of risk categories derived from 45 CFR 46.

<table>
<thead>
<tr>
<th>ADULT</th>
<th>ADULT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal Risk</td>
<td>Greater Than Minimal Risk</td>
</tr>
</tbody>
</table>

Activity where the probability and magnitude of harm or discomfort anticipated in the research is not greater in and of themselves than those ordinarily encountered in daily life or during performance of routine physical or psychological examinations or tests.

Research involving greater risk of harm than ordinarily encountered in daily life or during the performance of routine physical or psychological examinations or tests, but presenting the prospect of direct benefit to the individual subjects; or the research presents no prospect of benefit to the subject, but is likely to yield knowledge about the disorder or condition.

<table>
<thead>
<tr>
<th>Pediatric</th>
<th>Pediatric</th>
<th>Pediatric</th>
<th>Pediatric</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category 1</td>
<td>Category 2</td>
<td>Category 3</td>
<td>Category 4</td>
</tr>
<tr>
<td>Minimal Risk</td>
<td>Greater than minimal risk, but presenting the prospect of direct benefit to individual subjects</td>
<td>Greater than minimal risk and no prospect of direct benefit to individual subjects but likely to yield important generalizable knowledge about the subject’s disorder or condition.</td>
<td>Otherwise not approvable, but presents an opportunity to understand serious health or welfare problems of children</td>
</tr>
</tbody>
</table>

New Protocols not eligible for expedited review will be reviewed by at least two IRB members chosen on the basis of expertise with the particular subject matter of the study. These individuals will serve as the Primary Reviewers and will be responsible for presenting the protocol to the convened IRB for discussion.

The IRB must deliberate on all studies classified as greater than minimal risk for the purpose of assigning the frequency of continuing review reports. The IRB may decide to review greater than minimal risk studies more frequently than every twelve months.
Type of IRB Review For New Protocols

There are three categories of review:

<table>
<thead>
<tr>
<th>Exempt Review</th>
<th>Expedited Review</th>
<th>Full Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>Some research falls into a category of research called exempt. Examples of this category are listed in 45 CFR 46.101. NOTE: Exempt research must be still be submitted to the IRB through ARIA for classification as Exempt by the IRB Chair/Desigee.</td>
<td>The proposed research is defined as minimal risk and falls within one of the OHRP approved expedited categories. Review by the fully convened IRB is not necessary. Approval may be given by the IRB Chair/Designee and reported to the next convened IRB meeting.</td>
<td>Research involves issues that do not qualify for exempt or expedited review. The research is reviewed by 2 Primary Reviewers who present their findings to a fully convened IRB for discussion and vote.</td>
</tr>
</tbody>
</table>

**Exempt Review**

UAMS requires all human subject research studies meeting, or appearing to meet, one of the Exempt criteria to be submitted through ARIA for review and approval by the IRB Chair/Designee. No Investigator or Department on campus shall have the authority to make this decision other than the IRB Chair/Designee. All research, including that in the Exempt categories, must meet at a minimum the principles outlined in the Belmont Report. The IRB Chair/Designee may require additional protections to meet these principles, including a level of informed consent appropriate to the research or review by the full committee.

Studies receiving an Exempt classification by the IRB Chair/Designee will be required to submit a one page Study Update each year in order to keep the study open. The IRB shall be made aware of any changes in the study scope or design prior to implementation of the changes to insure that the study continues to meet the Exempt Criteria.

FDA allows two categories of clinical investigations to be considered exempt from IRB review. However, the IRB requires review of both categories. The FDA emergency use of a
test article process can be found at IRB Policy and Procedures 18.3 (Emergency Use of a Drug or Biologic) and 18.4 (Emergency Use of an Unapproved Medical Device). The other allowable FDA exempt category is listed below as #6 (Taste and food quality evaluation).

No research involving, or potentially involving, prisoners, as participants may be classified under the Exempt Categories listed below.

How To Apply For Exemption

Research that falls into any of the six categories listed below from 45 CFR 46.101 should be submitted in ARIA.

The IRB Chair/Designee, NOT the Investigator, determines if a study may be considered in the exempt category.

Categories of Exemption (Per 45 CFR 46.101)

1. Research conducted in established or commonly accepted educational settings, involving normal educational practices, such as research on regular and special education instructional strategies, or research on the effectiveness of or the comparison among instructional techniques, curricula, or classroom management methods.

   NOTE: This category may be applied to research involving children.

   NOTE: This category may not be applied to FDA regulated research.

2. Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures or observation of public behavior, unless:

   a. Information obtained is recorded in such a manner that human subjects can be identified, directly or through identifiers linked to the subjects and

   b. Any disclosure of the human subjects' responses outside the research could reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, or reputation.

   NOTE: The section of this category pertaining to standardized educational tests may be applied to research involving children. This category may also apply to research with children when the investigator observes public behavior but does not participate in that behavior or activity. This section is not applicable to survey or interview research involving children.

   NOTE: This category may not be applied to FDA regulated research.
3. Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement),
survey procedures, interview procedures, or observation of public behavior that is not exempt under paragraph (b) above, if:

a. The human subjects are elected or appointed public officials or candidates for public office or

b. Federal statute(s) require(s) without exception that the confidentiality of the personally identifiable information will be maintained throughout the research and thereafter.

NOTE: This category may not be applied to FDA regulated research.

4. Research involving the collection or study of existing data documents, records, pathological specimens, or diagnostic specimens, if these sources are publicly available or if the information is recorded by the investigator in such a manner that subjects cannot be identified, directly or through identifiers linked to the subjects.

a. To qualify for this exemption the data, documents, records, or specimens must be in existence before the project begins. Investigator must describe where the information exists.

b. Under this exemption, an investigator (with proper institutional authorization) may inspect identifiable records, but may only record information in a non-identifiable manner. Investigator must describe how information will be obtained, what data elements will be recorded, and whether any links to identifiers will be recorded.

NOTE: Inclusion of fetal tissue in the pathological specimens category of exempt research is prohibited by regulation and requires additional IRB review.

NOTE: This category may not be applied to FDA regulated research.

5. Research and demonstration projects which are conducted by or subject to the approval of federal Department or Agency heads, and which are designed to study, evaluate, or otherwise examine:

a. Public benefit or service programs; this exemption is for federally supported projects and is most appropriately invoked with authorization or concurrence by the funding agency. The following criteria must be satisfied to invoke the exemption for research and demonstration projects examining "public benefit or service programs."

i. The program under study must deliver a public benefit (e.g., financial or medical benefits as provided under the Social Security Act) or service (e.g., social, supportive, or nutrition services as provided under the Older Americans Act)
ii. The research or demonstration project must be conducted pursuant to specific federal statutory authority.

iii. There must be no statutory requirement that an Institutional Review Board review the project.

iv. The project must not involve significant physical invasions or intrusions upon the privacy of participants.

b. Procedures for obtaining benefits or services under those programs;

c. Possible changes in or alternatives to those programs or procedures;

d. Possible changes in methods or levels of payment for benefits or services under those programs.

e. Before invoking this exemption, the IRB will obtain concurrence of the funding agency that this exemption can be applied.

NOTE: This category may not be applied to FDA regulated research.

6. Taste and food quality evaluation and consumer acceptance studies if:

a. wholesome foods without additives are consumed or

b. if a food is consumed that contains a food ingredient at or below the level and for a use found to be safe, or agricultural chemical or environmental contaminant at or below the level found to be safe, by the Food and Drug Administration or approved by the Environmental Protection Agency or the Food Safety and Inspection Service of the U.S. Department of Agriculture.

NOTE: This category may be applied to children.

NOTE: This category may be applied to FDA regulated research.

Any research plan that involves both exempt and non-exempt research activities must be reviewed by the IRB.

Procedure:

1. The Investigator will:

   1. Submit a protocol and application through ARIA, including all surveys, questionnaires or other instruments to be used.
   2. Provide any additionally requested information.
3. Submit any proposed or anticipated changes to the IRB, through ARIA Modifications, prior to implementation.
4. On an annual basis, submit an Exempt Study Update Form if desiring to keep study open.

2. The IRB Director or Designee will:
   1. Review all requests for exemption.
   2. Request additional information as necessary.
   3. Document in the Office Notes section of ARIA whether the study appears to qualify for requested category.
   4. Draft Approval letter for Chair/Designee signature, or notify Investigator that the study will need to be reviewed by either Expedited or Full procedures.
   5. Place on Agenda under Exempt Studies Approved by the Chair/Designee.

3. The IRB Chair/Designee will:
   1. Review submitted documents and Office Notes.
   2. Request additional information as necessary.
   3. Determine that the research meets the organization’s ethical standards.
   4. Determine that the research does not involve prisoners as participants.
   5. Determine the category of the exemption and document the category on the Comments section of ARIA.
   6. If the research falls into one or more categories of exemption, and meets the organization’s ethical standard, grant a determination that the research is exempt and document that determination on the Comments section of ARIA.
   7. If the IRB Chair/Designee cannot grant an exemption, the IRB Chair/Designee should request modifications from the Investigator that would allow the research to be exempt. If the Chair/Designee and Investigator cannot reach agreement the research will be referred to the convened IRB for review.
   8. Request approval letter or modification letter be prepared for signature and placement on agenda as Exempt Studies Approved by Chair/Designee.

For more information on the criteria for studies classified as Exempt under the Federal Regulations, see IRB Policy 7.3 (Exempt Categories of Research).
**Expedited Review (Per 45 CFR 46.110)**

Some types of research do not necessitate review by the convened IRB. These types of studies may be approved by the IRB Chair/Desigee and reported to the convened IRB at its next meeting.

An expedited review consists of a review of research involving human subjects by the appropriate IRB Committee Chair or his/her designee. In reviewing the research, the reviewer may exercise all of the authorities of the full Committee except that the reviewer may not decline the research. Additionally, the reviewer may refer the application to the full Committee for a standard review as warranted.

**An Investigator may apply for expedited review, or the IRB Chair/Designee may determine that the study is eligible for expedited review if it meets the regulatory criteria. If the IRB Chair/Designee determines that the project submitted for expedited review requires full committee review, the Investigator will be notified in writing.**

**The IRB, NOT the Investigator, determines if a study may be considered in the Expedited Review category.**

- For a new protocol to qualify for Expedited Review, the research must:
  1. Present no more than minimal risk to human subjects;
  2. Not involve the identification of the subjects and/or responses which would reasonably place them at risk of criminal or civil liability or be damaging to the subjects’ financial standing, employability, insurability, reputation, or be stigmatizing, unless reasonable and appropriate protections will be implemented so that risks related to invasion of privacy and breach of confidentiality are no greater than minimal;
  3. Not be classified; and
  4. Involve only procedures listed below. Inclusion on the list does not automatically make the research minimal risk. It merely means that the activity is eligible for review provided the circumstances of the specific proposal involve no more than minimal risk to the participants.

Minimal Risk means that the probability and magnitude of harm or discomfort anticipated in the research are not greater in and of themselves than those ordinarily encountered in daily life or during the performance of routine physical or psychological examinations or tests.

**Categories of Expedited Review for New Protocols**

The categories on the list apply regardless of the age of subjects, except as noted.
1. **Clinical studies of drugs and medical devices** only when the conditions below are met.

   a. Research on drugs for which an investigational new drug application is not required. (Note: Research on marketed drugs that significantly increases the risks or decreases the acceptability of the risks associated with the use of the product is not eligible for expedited review.); or

   b. Research on medical devices for which (i) an investigational device exemption application is not required; or (ii) the medical device is cleared or approved for marketing and the medical device is being used in accordance with its cleared/approved labeling.

2. **Collection of blood samples** by finger stick, heel stick, ear stick, or venipuncture as follows:

   a. From healthy, nonpregnant adults who weigh at least 110 pounds. For these subjects, the amounts drawn may not exceed 550 ml in an 8 week period and collection may not occur more frequently than 2 times per week; or

   b. From other adults and children, when the age, weight, and health of the subjects, the collection procedure, the amount of blood to be collected, and the frequency with which it will be collected are considered. For these subjects, the amount drawn may not exceed the lesser of 50 ml or 3 ml per kg in an 8 week period and collection may not occur more frequently than 2 times per week. Children are defined in the federal regulations as "persons who have not attained the legal age for consent to treatments or procedures involved in the research, under the applicable law of the jurisdiction in which the research will be conducted". In Arkansas, this age is 18 years old.

3. **Prospective collection of biological specimens for research purposes by noninvasive means**, for example:

   a. Hair and nail clippings in a nondisfiguring manner;

   b. Deciduous teeth at time of exfoliation or if routine patient care indicates a need for extraction;

   c. Permanent teeth if routine patient care indicates a need for extraction;

   d. Excreta and external secretions (including sweat);

   e. Uncannulated saliva collected either in an unstimulated fashion or stimulated by chewing gumbase or wax or by applying a dilute citric solution to the tongue;

   f. Placenta removed at delivery;

   g. Amniotic fluid obtained at the time of rupture of the membrane prior to or during labor;
h. Supra and subgingival dental plaque and calculus, provided the collection procedure is not more invasive than routine prophylactic scaling of the teeth and the process is accomplished in accordance with accepted prophylactic techniques;

i. Mucosal and skin cells collected by buccal scraping or swab, skin swab, or mouth washings;

j. Sputum collected after saline mist nebulization.

4. **Collection of data through noninvasive procedures** (not involving general anesthesia or sedation) routinely employed in clinical practice, excluding procedures involving x-rays or microwaves. Where medical devices are employed, they must be cleared/approved for marketing. (Studies intended to evaluate the safety and effectiveness of the medical device are not generally eligible for expedited review, including studies of cleared medical devices for new indications.) Examples:

a. Physical sensors that are applied either to the surface of the body or at a distance and do not involve input of significant amounts of energy into the subject or an invasion of the subject’s privacy;

b. Weighing or testing sensory acuity;

c. Magnetic resonance imaging;

d. Electrocardiography, electroencephalography, thermography, detection of naturally occurring radioactivity, electroretinography, ultrasound, diagnostic infrared imaging, doppler blood flow, and echocardiography;

e. Moderate exercise, muscular strength testing, body composition assessment, and flexibility testing where appropriate given the age, weight, and health of the individual.

f. Collection of data from voice, video, digital, or image recordings made for research purposes.

5. **Research involving materials (data, documents, records, or specimens) that have been collected, or will be collected solely for non-research purposes (such as medical treatment or diagnosis).** (NOTE: Some research in this category may be exempt from the requirement that it obtain IRB approval [See IRB Policy 7.3]. (This listing refers only to research that is not exempt.)

6. **Collection of data from voice, video, digital, or image recordings made for research purposes.**

7. **Research on individual or group characteristics or behavior** (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.
(NOTE: Some research in this category may be exempt from the requirement that it obtain IRB approval (See IRB policy 7.3 – Exempt Categories of Research). (This listing refers only to research that is not exempt.)

Continuing review of research by the expedited procedure must meet one of the following criteria:

1. Meet the criteria for initial review by an expedited procedure; or

2. Be permanently closed to the enrollment of new subjects, where all subjects have completed all research-related interventions; and the research remains active only for long-term follow up of subjects; or

3. No subjects have been enrolled and no additional risks have been identified; or

4. The remaining research activities are limited to data analysis; or

5. Meet all of the following criteria:
   5.1 Not be conducted under an investigational new drug application or investigational device exemption,
   5.2 Not otherwise qualify for review by the expedited procedure; and
   5.3 The IRB has determined and documented at a full Committee convened meeting that the research involves no greater than minimal risk and no additional risks have been identified.

Modifications can be expedited if the modification is minor. A change is considered minor when it does not materially affect an assessment of the risks and benefits of the study; does not substantially change the aims or design of the study; and is not directly relevant to the determinations required for approval. Examples of items that generally might be considered appropriate for expedited review and approval: Changes in research personnel or contact information, minor changes to the protocol or consent document in order to clarify or correct earlier information provided there is no change in the evaluated risks or potential for benefit.

- Investigator Procedure:

1. For Initial Review of an Expedited Protocol, Investigator must:
   1.1 Submit in ARIA all required new application materials as outlined in IRB Policy 7.4 and select the expedited category s/he believes the study to fit.

2. For Continuing Review under Expedited Procedures:
   2.1 Submit in ARIA a Continuing Review Report noting on the form which criteria for expedited continuing review the project meets.
3. For Modifications to be reviewed under Expedited Procedures:

3.1 Submit in ARIA a Modification form noting in the section entitled “Description of any significant change in the risk/benefit” that the requested modification does not materially affect an assessment of the risks and benefits of the study; does not substantially change the aims or design of the study and is not directly relevant to the determinations required for approval.

- IRB Procedure:

1. For Initial Review of an Expedited Protocol, IRB Chair/Designee must:

   1.1 Review materials in sufficient detail in order to determine that the study meets the criteria for approval as outlined in IRB Policy 7.1.
   
   1.2 The Chair or designee must determine that the research meets all criteria outlined in section 1 above allowing review by the expedited procedure.
   
   1.3 Determine that the research does not involve prisoners as participants. If the study involves prisoners, direct the IRB Staff to place the study on the full board section of the agenda for the next meeting in which the Prisoner Representative can attend.
   
   1.4 Determine the expedited category into which the study fits and document the category on the Comments section of ARIA.
   
   1.5 If study as designed does not meet any of the expedited categories, the IRB Chair should request modifications from the Investigator that would allow the research to be expedited. If the Chair and Investigator cannot reach agreement the research will be referred to the convened IRB for review.
   
   1.6 Request approval letter or modification letter be prepared for signature and placement on agenda as Expedited Actions Approved by Chair.

2. For Continuing Review under Expedited Procedures IRB Chair/Designee must:

   2.1 Follow all elements of IRB Policy 7.6 and document that the research meets one of the criteria outlined above in Expedited Review Requirements, Section 3.

3. For Modifications to be reviewed under Expedited Procedures, IRB Chair/Designee must:

   3.1 Determine that the requested modification truly does not materially affect an assessment of the risks and benefits of the study; does not substantially change the aims or design of the study and is not directly relevant to the determinations required for approval.

For more information, see IRB Policy 7.5 (Expedited Review).

The IRB must uphold the standard requirements for informed consent (or its waiver, alteration, or exception) regardless of the type of review (expedited or convened) used.

When performing an expedited review, the reviewer(s) may exercise all of the authorities of the IRB except that they may not disapprove the research. Research may only be disapproved by the convened IRB. IRB Reviewers have access to all information submitted on any project which has received approval or been amended through an expedited review process.
• Full Review

All applications except those qualifying for exempt or expedited status will be reviewed by the IRB at one of its convened meetings. The IRB utilizes primary review teams in conducting full reviews. A minimum of two reviewers will receive the full study protocol application. All committee members will have access to the IRB application forms, protocol summary, and informed consent documents. The Primary Reviewers will present the protocol and issues to the convened IRB for discussion before a vote for approval can be cast.

A quorum (51% of the specific committee’s voting membership including the chair) of members, including at least one non-scientific member, must be present for voting purposes on each review. After the vote, the Investigator will be notified in writing regarding the status of the application.

❖ IRB Review Results

The IRB will review research protocols and approve, disapprove, or require modifications before approval is granted. Investigators are notified in writing concerning all IRB actions.

If the IRB disapproves a study, it will notify the Investigator of the reasons for the disapproval, and allow the Investigator an opportunity to respond. The Investigator may appeal to the IRB to reverse the decision to disapprove a study, but no other authority may approve a study if the IRB disapproves it.

IRB Review results of new protocols fall into the following categories:

• Protocol Approved:
The project and its study tools, including the informed consent documents, are approved as submitted. Once the Investigator receives the IRB approval letter, the study may begin.

• Protocol Approval Deferred (Major or Minor):
The project requires revisions, which the IRB can list as part of the motion. The PI will be provided with comments explaining rationale for the decision and given an opportunity to respond. If Major, these must be addressed and re-reviewed by the convened IRB before the IRB can grant approval. The response will be reviewed by the convened IRB. If deemed Minor, these revisions may be reviewed through the expedited process.

• Protocol Tabled:
The project has serious deficiencies in submitted protocol. These must be addressed and re-reviewed by the convened IRB before the IRB can grant approval. The PI will be provided with comments explaining rationale for the decision and given an opportunity to respond. The response will be reviewed by the convened IRB. PIs should be aware that the IRB upon receiving the responses to a tabled motion may have additional requested revisions.

• Protocol Declined:
The project has serious deficiencies in submitted protocol that affecting the safety and welfare of the projected subject population. These must be addressed in a new protocol and be reviewed by the convened IRB before the IRB can grant approval. The PI will be provided with comments explaining rationale for the decision and given an opportunity to respond. The response will be reviewed by the convened IRB.
Any involvement of human subjects in research may not begin until the approval of the IRB has been received.

❖ Notification Of Investigators Following Review

The IRB office, through ARIA, notifies each Investigator of the review of their initial protocol submission, correspondence received by the IRB office, protocol activities reported at the IRB meeting, and continuing review process. The notification should be issued within 14 business days and outline the IRB actions and any further issues which must be addressed by the principal Investigator. Upon receipt of that notification the PI, or designee, should make the required corrections, modifications, or resubmission of a new protocol through ARIA.

All correspondence with the IRB must be submitted in ARIA under the IRB number or reference the IRB Record number. Correspondence that does not identify the IRB number may be returned without further action.

❖ Notification Of Institutional Officials

The minutes of the IRB meetings reflect summarized discussion of protocol issues and documentation of the vote on each IRB action. Upon request, a copy of the IRB minutes will be sent to the Vice-Chancellor for Academic Affairs and Sponsored Research.
Guidelines for Blood Draws in Pediatric and Adult Populations

Note: For requests greater than the maximum draw, please contact the attending physician for approval of additional amounts for inpatients and the laboratory pathologist for additional amounts for outpatients.

Maximum Allowable Blood Draw Volumes Chart Based on Body Weight in Kilograms
(Revised 09/2002)

<table>
<thead>
<tr>
<th>Body Weight In Kg</th>
<th>Maximum Drawn In One Blood Draw</th>
<th>Maximum Drawn In A 30 Day Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Kg</td>
<td>2.5 ml</td>
<td>23 ml</td>
</tr>
<tr>
<td>2 Kg</td>
<td>4.5 ml</td>
<td>23 ml</td>
</tr>
<tr>
<td>3 Kg</td>
<td>6 ml</td>
<td>23 ml</td>
</tr>
<tr>
<td>4 Kg</td>
<td>8 ml</td>
<td>30 ml</td>
</tr>
<tr>
<td>5 Kg</td>
<td>10 ml</td>
<td>40 ml</td>
</tr>
<tr>
<td>6 Kg</td>
<td>12 ml</td>
<td>40 ml</td>
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<tr>
<td>7 Kg</td>
<td>14 ml</td>
<td>40 ml</td>
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<tr>
<td>8 Kg</td>
<td>16 ml</td>
<td>60 ml</td>
</tr>
<tr>
<td>9 Kg</td>
<td>18 ml</td>
<td>60 ml</td>
</tr>
<tr>
<td>10 Kg</td>
<td>20 ml</td>
<td>70 ml</td>
</tr>
<tr>
<td>11 thru 15 Kg</td>
<td>22-30 ml</td>
<td>70-100 ml</td>
</tr>
<tr>
<td>16 thru 20 Kg</td>
<td>32-40 ml</td>
<td>130-140 ml</td>
</tr>
<tr>
<td>21 thru 25 Kg</td>
<td>42-50 ml</td>
<td>160-180 ml</td>
</tr>
<tr>
<td>26 thru 30 Kg</td>
<td>52-60 ml</td>
<td>200-220 ml</td>
</tr>
<tr>
<td>31 thru 35 Kg</td>
<td>62-70 ml</td>
<td>240-250 ml</td>
</tr>
<tr>
<td>36 thru 40 Kg</td>
<td>72-80 ml</td>
<td>270-290 ml</td>
</tr>
<tr>
<td>41 thru 45 Kg</td>
<td>82-90 ml</td>
<td>290-330 ml</td>
</tr>
<tr>
<td>46 thru 50 Kg</td>
<td>92-100 ml</td>
<td>330-350 ml</td>
</tr>
<tr>
<td>Greater than 51 Kg</td>
<td>100 ml</td>
<td>350 ml</td>
</tr>
</tbody>
</table>

Reference: 2.2 lb = 1 Kg

This information, for single draw, is similar to that recommended by the Committee on Clinical Investigations at Children’s Hospital in Los Angeles, and also used at Baylor College of Medicine in Dallas, Texas, and at Children’s Hospital and Regional Medical Center Laboratory in Seattle, Washington. The maximum draw volumes for a 30-day period are similar to those recommended by Becan-McBride, Phlebotomy Handbook (5th edition).

Adapted by Paula North, M.D., Ph.D., August 2002, Arkansas Children’s Hospital, Little Rock, Arkansas. Approved by ACH Patient Care Committee September 2002.
CHAPTER 4

Protocol Submissions

This chapter instructs Investigators how to submit new protocols.

Investigator Requirements

Prior To Submission

Definition Of Research

Responsibilities Of The Principal Investigators When Submitting A Study For IRB Approval

- Study Closure Information

Planning The IRB Submission

- Mandatory Education
- Study Design
- Designating The Principal Investigator
- Sub-investigators
- Student Conducted Research

Specifying The Number Of Research Subjects

Women And Minorities In Study Populations

Students As Research Subjects

Employees As Research Subjects

Research Informed Consent

HIPAA

Approval Bodies And Committees

- Other IRBs
- ACH/ACHRI
- Ionizing Radiation
- Oncology Research
- Recombinant DNA and/or Biohazardous Protocols
- General Clinical Research Center (GCRC)
- Grants and Funding Sources
- Pharmacy
- VA R & D Committee
- Institutional Biosafety Committee
- Conflicts of Interest Committee

Using Investigational New Drugs
Using Investigational New Devices
Advertisement For Subject Recruitment
Collaborating With Other Institutions
Data Safety Monitoring Information

Application Forms and Original Signatures
IRB Protocol Submissions Requirements Using ARIA
How To Submit A New Study Protocol Using ARIA
Investigator Requirements

In order to best protect those participating in research, Investigators should have the necessary training and background to conduct studies in accordance with the protocol, organizational policies and procedures, applicable regulations, such as those concerning IRB review, informed consent requirements, reporting requirements, maintenance of records, retention of records, and supervision of research conduct.

Before undertaking a project, an investigator needs to determine if s/he has the time, equipment and necessary staff in terms of numbers and/or qualification in order to conduct the research in a way that will protect participants.

For more information on Investigator qualification and requirements, see IRB Policy 7.2 (Investigator Qualifications).

Prior To Submission

Prior to preparing a research application, Investigators should consider the following:

- Does the project involve research, as defined below?
- Will the project involve living human subjects or their identifiable information?

Definition Of Research

Research is a systematic investigation, including research development, testing, and evaluation designed to develop or contribute to generalized knowledge [45CFR46.102(d)]. Examples of research activity include clinical investigations, clinical trials, surveys, interviews, behavioral investigations, retrospective reviews of medical information, experiments with blood and tissue, and demonstration or service programs.

Responsibilities Of The Principal Investigator When Submitting A Study For IRB Approval

The Principal Investigator (PI) has the responsibility of submitting his/her proposed research for approval prior to accessing any information or to any human subject enrollment. The PI must assure that all persons performing research activities under his/her direction are properly credentialed by the institution to perform the procedures or interventions outlined in the research protocol. Approval by the IRB does not relieve the PI from the obligation to follow procedures and rules of the institution(s) at which the research is to be undertaken.

Each PI is responsible for providing assurance to the IRB that activity on the approved protocol is continuous. Investigators must also maintain continuous approval from each institution(s) where the research is being conducted. The study must be reviewed and re-approved by IRB not less than one year from the date of study approval. If this continuing review report (CRR) is not approved by the date specified, the study no longer has approval and a letter of study suspension will be issued. No new subjects may be enrolled until approval of the CRR is obtained from the IRB and all interactions with currently enrolled subjects must cease unless for subject safety the IRB specifically approves continued interaction. If the PI does not respond to subsequent IRB request for
continuing review reports, the study will be terminated. Patterns of noncompliance by the Investigator can trigger formal inquiries by the IRB.

The validity of the CRR information must be supported in the study records. The PI has the responsibility to monitor study records for completeness, accuracy, authenticity, and validity.

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**The PI (or his/her formally authorized designee) must sign ALL communication with the IRB. The IRB must approve the alternate or formally authorized signatory. Communication not signed by the appropriate person will be returned.**

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**Study Closure Information**

At the conclusion of any study, the PI must submit a Study Closure form to the IRB through ARIA, including applicable data analysis and long-term follow-up, so that the study can be closed. The final report of study results should be received by the IRB within 30 days of decision to close a study. Investigators may request closure of a study upon continuing review or by submitting a separate study closure form. When a protocol is complete except for data analysis or long-term follow-up, the PI should indicate the status of the protocol on the CRR so that approval can be expedited. Studies are not to be closed until the Investigator has determined that the study no longer needs access to any identifiable information.

**The PI is responsible for abiding by the Investigator’s Agreement that includes the following items:**

- No subjects will be recruited or entered into a protocol until the Investigator has received an approval letter from the IRB.
- No modification of the protocol or consent form will be initiated without prior written approval from the IRB, except when necessary to eliminate immediate hazards to the subjects. Exceptions for immediate hazards must be reported orally to the IRB Chair or Designee immediately.
- The PI will provide a prompt, written report to the IRB regarding any deviation from the protocol and/or consent form, adverse events that are serious, unexpected and related to the study, or a death occurring during the study.
- Annual status reports for the protocol (CRR) will be completed and returned within the time limit stated on the forms.
- If the study involves any funding or resources (such as drugs or devices) from outside sources, the Grants Coordinator in the appropriate Institutional Research Administration Office must be contacted regarding a contract. Subjects cannot be enrolled prior to completion of the contract, unless specified by the institution.
• If the study involves industry sponsored trials at the VA, the PI must contact the Biomedical Research Foundation

• Informed consent will be obtained from all subjects using the method approved by the IRB for the research protocol, unless waived by the IRB.

• The IRB office will be notified within 30 days of a change in the PI.

• The PI will sign via ARIA a statement regarding the protection of human subjects and vulnerable populations.

Failure to abide by the approved research plan can lead to suspension or termination of studies or to suspension of the PI's research privileges by the IRB.

❖ Planning The IRB Submission

❖ Mandatory Education

As of January 31, 2004, all research staff involved with human subject studies must have completed the on-line Human Subject Training (HST) course and the on-line HIPAA for Research course.

Two different on-line HST courses are offered: the Biomedical Course on Human Subject Protection Training and the Behavioral and Social Science Course on Human Subject Protection Training. Only one HST course is required, and the research staff should select the one most appropriate to the type of research in which they will be involved.

The Biomedical Course is appropriate for persons whose research involves drugs, devices, and surgical/invasive procedures. The Behavioral and Social Science course is relevant to those disciplines and is not appropriate for Investigators whose research involves drugs, devices or surgical/invasive procedures. Both courses integrate UAMS IRB requirements.

All three of these on-line courses are found by selecting the Training button on the Office of Research Compliance website at www.uams.edu/orc. Then select “Online Course Registration”. You will be asked to type in some demographic information. This will register you for the appropriate courses through WebCT.

The HIPAA for Research course is in additional to any general HIPAA course that may be required by an Institution for all of its employees.

❖ Study Design

Investigators should understand that the human research must be conducted using a research plan or “protocol” that has been submitted and approved by the IRB. Grant applications may not be submitted in lieu of a protocol. All changes in the protocol must be approved by the IRB before implementing, unless the change is urgently required for the subject’s safety. The PI must contact the IRB Chair immediately if such urgent safety conditions will alter the protocol or consent.
Investigators must submit a clinical research protocol detailing all aspects of the proposed human studies. This document is distinctly different than the grant application for funding the proposed project in that it provides the IRB with details of how all phases of the human studies will be conducted. Investigators must also submit the research portion of any grant proposal for which IRB approval is sought, however the IRB does not accept a grant proposal in lieu of a detailed description of how all human studies are to be accomplished.

Plans for human research should reflect appropriate consideration on the part of the Investigator of all aspects of the proposed research. Specifically, the questions that the PI proposes to answer and the precise methodology needed to obtain those answers must be included in the research plan.

- **Designating The Principal Investigator**

A research project is headed by a Principal Investigator (PI). The PI leads the research team, directs the project, and bears ultimate responsibility for its conduct.

The IRB must ensure that the PI has the requisite training and experience that the project requires. Documented HST and HIPAA for Research training is required of the PI, Investigators and the research team.

Whenever there is a change in the PI or in the PI's status that affects the project, the IRB must be notified.

- **Sub-Investigators**

If the study requires collaboration from another area, a Sub-Investigator from that area can be designated. The Sub-Investigator should be consulted and familiarized with his/her responsibilities. A copy of the Sub-Investigator’s curriculum vitae or resume and license (if appropriate) should be included in the study submission. If an FDA form 1572 is required for the study, it must be kept updated if there is a change in Sub-Investigators.

Cooperative groups, such as COG (Children’s Oncology Group) or SWOG (Southwest Oncology Group) does not allow non-members, including residents and students, to conduct research.

- **Student Conducted Research**

All activities that meet the definition of research with human subjects and that are conducted by students for a class project or for work toward a degree must be reviewed by the IRB. Resident physicians are considered students. For example, activities that must be reviewed and approved by the IRB include:
a. All master’s theses and doctoral dissertations that meet the definition of research and involve human subjects or their data; and

b. All projects that involve human subjects or their data and for which findings may be published or otherwise disseminated.

**Oversight by Faculty/Advisor.** All students/fellows residents in UAMS applying as PI on a study for IRB review must list their faculty advisor as a Co-Investigator. The faculty member should be listed as PI if there is contemplation of continuing the student’s work following their matriculation.

**Specifying The Number Of Research Subjects**

The IRB is required to protect subjects from the first contact for possible recruitment. All subjects who go through the recruitment process even if they fail screening or decline participation at a later date must be accounted for. Thus, total accrual is the number of subjects go through the consent process. Initial requests for subject accrual should be large enough to reflect accurate accrual goals plus any screen failures and anticipated drop-out rates.

The application must specify the number of study subjects to be accrued, grouped by age, gender, and population diversity. Exceeding the accrual limits approved by the IRB is a violation of the protocol. The IRB must give prior written approval for any increase in subject accrual.

Multi-center studies, in which data will be pooled and recruitment may vary, present a special problem for Investigators. The application should provide information about the total picture, including both the number of subjects to be studied locally and the number studied at all sites.

**Women And Minorities In Study Populations**

The study plan should be designed so that research benefits and burdens are fairly distributed. If an individual or group is denied access to a clinical trial that might be beneficial or if some people are singled out to bear the burden of risks associated with a study, the requirement for fairness is not met.

In accordance with the policies of the National Institutes of Health, the IRB requires researchers applying for federal funds to give breakdowns of their subject populations by gender and minority group. Studies with the potential to address issues relevant to both sexes must recruit both genders, and minority populations should be included in a study population wherever feasible. Researchers must justify the exclusion of any group of individuals. The IRB may make exceptions if there is adequate scientific justification for exclusion, such as when a disease predominates in one gender or the focus of the research question is on a specific group.

**Students As Research Subjects**

When students are to be accrued for research, consent must state that students are allowed to refuse participation or withdraw early from a study without affecting their academic standing at UAMS. Prohibiting all student participation in research, however, may be an overprotective reaction. An alternative way to protect against coercion is to require that Faculty-Investigators advertise for subjects generally (e.g., through notices posted in the school or department) rather than recruit
individual students directly. As with any research involving a potentially vulnerable subject population, the IRB will pay special attention to the potential for coercion or undue influence and consider ways in which the possibility of exploitation can be reduced or eliminated.

Confidentiality is a concern raised by the involvement of students as subjects in research. The IRB will consider that research involving the collection of data on sensitive subjects such as mental health, sexual activity, or the use of illicit drugs or alcohol presents risks to subjects of which they should be made aware and from which they should be protected, to the greatest extent possible. The close environment of the university amplifies this problem.

For more information, see Chapter 12, Research Involving Vulnerable Populations and IRB Policy 17.10 (Students, Employees and Healthy Volunteers).

- **Employees As Research Subjects**

The issues with respect to employees as research subjects are essentially identical to those involving students as research subjects: coercion or undue influence, and confidentiality. Employee research programs raise the possibility that the decision will affect performance evaluations or job advancement. Maintaining the confidentiality of personal medical information or research data when the subjects are also employees, particularly when the employer is also a medical institution [Meyers (1979)] is difficult. For issues regarding compensation each affiliated institution may have policies that apply. The Investigator is responsible for following those policies.

For more information, see Chapter 12, Research Involving Vulnerable Populations and IRB Policy 17.10 (Students, Employees and Healthy Volunteers).

- **Research Informed Consent**

Informed Consent is an ongoing process. The research informed consent process should be detailed in the submission process. All consent documents must be written according to federal regulations and IRB requirements and should be consistent with study protocols. All informed consent documents must be approved by the IRB. For more information on the Informed Consent process, see Chapter 5, Informed Consent.

- **HIPAA**

According to the UAMS Administrative Guide, the scope of the HIPAA Research Policy (Research alone OR combined with treatment) applies to all UAMS physicians, faculty, employees and students performing research on human subjects (living or deceased) or their data, or conducting review of Protected Health Information (PHI) preparatory to research. For research conducted in a non-UAMS physical location, such as Arkansas Children’s Hospital, the policies of that institution will apply.

UAMS policy is to protect the privacy and confidentiality of medical records and information contained in the medical records of persons who are subjects of UAMS Research projects, including any and all Protected Health Information as defined by the HIPAA Privacy Regulations. Protected Health Information of a Research subject, and the use or disclosure of such information, shall be governed by the UAMS Research policy and any other applicable UAMS policies.
This HIPAA Research Policy does not replace the legal requirements or UAMS policies concerning compliance with the Common Rule, FDA regulations, or other applicable laws.

**Approval Bodies And Committees**

Approval or clearance from various bodies located in all of the institutions where the research will occur is required prior to beginning your study. The Investigator will present appropriate letters of approval with the protocol submission to the IRB for review or as soon thereafter as possible.

If you plan to conduct your study at more than one institution that uses the UAMS IRB as its IRB of record, an approval letter or a copy of the application letter for each institution’s appropriate committee (i.e., VA R&D, PRMC, radiation safety, biosafety, etc.) will be required prior to starting your research project. The PI remains responsible for ensuring that all of the appropriate committee approvals are in place prior to conducting the research. **Do not start any research until all approval letters have been received.**

The UAMS IRBs functions independently of (but coordinates its activities with) other committees and departments at UAMS, CAVHS, ACH and ACHRI. The IRBs will work in conjunction with other university or institutional committees; however, it will review research projects independently to ensure that human participants will be adequately protected. For more information, see [IRB Policy 2.2 (To Other University or Affiliated Committees/Departments)].

- **Other IRBs**

  In order for the UAMS IRB to rely on another IRB for any review, it must be AAHRPP accredited.

  The investigator MUST inform the IRB of all sites and FWAs of those sites where the study will take place and any other IRBs and FWAs of those IRBs that will be involved.

Questions about this should be referred to the IRB assistant director or via email at irb@uams.edu. For more information, see [IRB Policy 2.3 (To Other Institutions)].

The number and composition of IRB Committees at UAMS may vary at times to support the volume and type of human research to be reviewed in a thorough and timely manner. Composition of the individual committees will in general be along the discipline lines of biomedical and behavioral and social sciences. Committees with a different focus may be added if warranted to meet the needs of the research program.

A contact list for these committees and other resources at the various institutions covered by the IRB is listed in the [Resource List of Committees and Institutional Contacts].

- **ACH/ACHRI**

  Research at Arkansas Children’s Hospital requires approval by the Arkansas Children’s Hospital’s Research Institute (ACHRI). For more information, contact the Legal and Human Protections Administrator, at 501-364-3571.
**Ionizing Radiation**

If the study includes ionizing radiation, it is the Investigator’s responsibility to obtain approval from the Radiation Safety Committee in each institution where the research will be performed if approval is required. For more information on the UAMS Radiation Safety Committee, contact the Radiation Safety Officer at 501-686-5299 or visit the UAMS Radiation Safety Committee website.

**Example:**

You plan to conduct a pulmonary study involving frequent chest x-rays and computerized tomography (CT) scans on subjects admitted to the VA and UAMS hospitals. An approval letter from or letter of application to each institution’s radiation safety committee will be required with your submission to the IRB.

**Oncology Research**

If the study involves oncology, the protocol may need to be submitted to the ACRC Protocol Review and Monitoring Committee (PRMC). This applies to both UAMS and CAVHS oncology protocols. The PRMC reviews all cancer protocols conducted under the auspices of the Arkansas Cancer Research Center for scientific merit, subject availability, and available resources. The PI is responsible for submitting oncology protocols to the PRMC for approval in addition to IRB approval. Clinical protocols that are NOT cancer-related, but have an ACRC member as a principal Investigator do not require PRMC approval.

**Recombinant DNA and/or biohazardous protocols**

Projects that require UAMS Biosafety Committee (IBC) approval before protocol submission to IRB include:

- Protocols involving NIH/CDC designated “select agents.”
- Experimentation using BL2 or BL3 infectious microorganisms
- Experimentation using carcinogenic (known or suspected) or highly toxic compounds.
- Recombinant DNA, if BL2 or BL3 organisms are involved or if genetic modification might increase pathogenicity, transmissibility, host range, or antibiotic resistance of a pathogen.
- The transfer of toxin genes lethal for vertebrates at an LD50 <100ng/kg.
- Modification of the germ-line genes of animals (transgenic)
- Human gene therapies even if recombinant DNA is produced elsewhere.
The UAMS Biosafety Committee completes its review of protocols as soon as possible after they are received. If the proposal involves the CAVHS, contact the VA research Office to submit to the VA Research Safety Committee. A list of contact numbers for the institutional subcommittees can be found in the Resource List of Committees and Institutional Contacts.

### General Clinical Research Center (GCRC)

The GCRC is a National Institutes of Health (NIH) funded grant primarily intended to leverage federal funding for Investigator-initiated, human-based research and serves the research communities of UAMS, CAVHS and ACH. The GCRC provides Investigators with specialized research space, dedicated research nursing support, dietary consultation and metabolic kitchen, biostatistical support, informatics consultation, design and maintenance, and specialized core laboratories.

Protocols are reviewed by the GCRC Advisory Committee (GAC) and must be received by the second Friday of each month for review on the first Friday of each subsequent month. In addition to GAC approval, each protocol must gain both IRB approval and VA R&D Committee approval prior to initiation on the GCRC. For more information, please access the GCRC website at [www.uams.edu/gcrc](http://www.uams.edu/gcrc) or call 501-257-5890.

### Grants and Funding Sources

Studies done at UAMS must be submitted to the Office of Research and Sponsored Programs (ORSP). Studies conducted at CAVHS must also be submitted to the Biomedical Research Foundation. At ACH, the studies are to be submitted to the Arkansas Children’s Hospital Research Institute. Funds are usually not released until IRB approval and institutional approval is obtained.

If a research study is grant initiated, it has to be first sent to the respective Research and Sponsored Programs Office. Grants cannot be awarded until all approval letters are submitted. For example, if a research study is funded by a NIH grant, the PI has to submit the study to the NIH first then submit it to the IRB. These submissions can occur simultaneously.

### Pharmacy

If the proposed research involves the use of a pharmaceutical, the pharmacy in each institution where the research will take place must be consulted. ACH, CAVHS, and UAMS all have policies requiring dispensing of all investigational drugs through their pharmacies. All pharmacies require Cost Impact Information forms to be completed.

The receipt, storage, and dispensing of drug will be overseen by each institution’s pharmacy. Each pharmacy requires information about the protocol and a copy of each subject’s informed consent documents. A list of Pharmacy Contacts is located in the Resource List of Committees and Institutional Contacts.
- **VA R & D Committee**

Research at Central Arkansas Veterans Healthcare System (CAVHS) requires approval by the VA Research and Development Committee (VA R&D). If you answer 'yes' to any of the following three statements, your study must be approved by the VA R&D before the study can begin: (1) The study involves VA patients or seeks to recruit from the VA patient population; (2) the study is funded by the VA; or (3) the study involves VA property (this includes a scenario in which the PI has office space on VA property or is using the GCRC). You will find submission instructions at [www.lrva-research.uams.edu](http://www.lrva-research.uams.edu). Additionally you may contact the Administrative Office for Research at 501-257-4816.

You may submit proposals simultaneously to the IRB and VA R&D. The VA R&D may approve a proposal 'pending IRB approval'. In these situations, once confirmation of IRB approval is received, the VA R&D will complete the 'final approval letter'.

Investigators conducting protocols with human subjects at CAVHS must complete additional required VA training in the mandatory instruction on human subject protections. Instructions for this training are found on the website indicated above.

- **Institutional Biosafety Committee**

Research involving the direct and deliberate transfer of biologically derived products listed below into human participants must receive approval from the appropriate Biosafety Committee before final IRB approval may be granted. The IRB may grant final approval pending approval of the Institution's Biosafety Committee. The IRB Chair or experienced IRB member designated by the Chair will review the approval of the Institution’s Biosafety Committee. If the approval raises issues or questions that are directly relevant to the determinations required by the IRB, or request more than minor changes to the research approved by the IRB, the information or changes will be placed on the agenda of a convened IRB meeting for review. Otherwise, the IRB Chair or experienced IRB member designated by the Chair may grant final approval under expedited procedures.

- Experimentation using BL2 or BL3 infectious microorganisms.
- Experimentation using carcinogenic (known or suspected) or highly toxic compounds.
- Recombinant DNA, if BL2 or BL3 organisms are involved or if genetic modification might increase pathogenicity, transmissibility, host range or antibiotic resistance of a pathogen. The transfer of toxin genes lethal for vertebrates at an LD₅₀ of <100 ng/kg.
- Modification of the germline genes of animals (transgenic).
- Human gene therapy even if the recombinant DNA is produced elsewhere.
- **Conflicts of Interest Committee**

  Research involving any actual or perceived conflicts of interest as per institutional policies. The IRB will not review research with a declared financial interest until the Conflicts of Interest Committee has completed its evaluation and any management. The written determination of the Conflicts of Interest Committee, and the reasons for those determinations will be provided to all IRB members for review at a convened meeting. ORSP maintains all the annual disclosures of conflicts of interest and the proposed management plan and will upon request provide the annual conflict of interest disclosure forms to the IRB Director, IRB Chair or their Designee. The IRB Director/Chair/Designee shall have access to conflict disclosures which may assist in forming the basis to ascertain the level of conflict or changes in conflict using the following criteria: If the financial conflict of interest management plan affects the IRB approval criteria, the IRB will not approve the project. The IRB may require the consent to reveal any conflict and management plan, even if the approval criteria are not affected.

  For more information about the different institutional committees, see [IRB Policy 2.2 (To Other University or Affiliated Committees/Departments)].

- **Using Investigational New Drugs**

  For information on using investigational new drugs in research studies, see [Chapter 11, Investigational Drugs and Medical Devices].

- **Using Investigational New Devices**

  For information on using investigational new devices in research studies, see [Chapter 11, Investigational Drugs and Medical Devices].

- **Advertising For Subject Recruitment**

  Studies may require the use of print, television, Internet or radio advertisement in order to accrue the subject population. Advertisements used for recruitment of subjects to participate in research protocols must be submitted to and approved by the IRB prior to use. Any type of advertising for research subjects that is intended to be seen or heard by possible subjects is considered to be part of subject selection process. The IRB must review both the information contained in the advertisement and the mode of its communications.

  Information placed on a website for the purposes of study recruitment must receive prior approval from the IRB.

  Advertisements should not be coercive and should not state or imply a certainty of favorable outcome or other benefits beyond what is outlined in the consent document and the protocol. No claims should be made, either explicitly or implicitly, that the drug, biologic or device is safe or effective for the purposes under investigation, or that the test article is known to be equivalent or superior to any other drug, biologic or device. Such representation would not only be misleading to potential participants but would also be a violation of the FDA regulations concerning the promotion of investigational drugs and investigational devices.
Advertising should not use the terms “New Treatment,” “New Medication,” or “New Drug” but rather the term “Investigational.”

Advertisements should not promise "free medical treatment," when the intent is only to say participants will not be charged for taking part in the investigation. The IRB will determine if the promise of treatment without charge is coercive to financially constrained participants. Advertisement may state that participants will be paid, but should not emphasize the payment or the amount to be paid.

Advertisements must include

- The name and address of Clinical Investigator and/or research facility
- The condition under study and/or the purpose of the research
- In summary form, the criteria that will be used to determine eligibility for the study
- A brief list of participation benefits, if any (e.g., a no cost health examination)
- The time or other commitment required of the participants
- The location of the research and the person or office to contact for further information.

Collaborating With Other Institutions

Collaboration with other institutions may be conducted at various levels. The IRB should be notified of the level of collaboration in order to ensure appropriate procedures are instituted. Questions regarding collaboration with other institutions may be emailed to: irb@uams.edu

If Institutional Review Board (IRB) review is required at each collaborating institution, there are options to providing required review as per Federal regulations. If the collaborating institution has a federally approved IRB, that IRB will review the study unless they request that the UAMS IRB be the IRB of record. If a collaborating institution chooses for the UAMS IRB to be their IRB of record, additional agreements must be entered into between the two institutions.

If a research project at UAMS is to be carried out in conjunction with another institution or entity and the UAMS IRB will be responsible for the review of the project, the IRB incurs certain aspects of liability that require additional information from the Investigator. An IRB Authorization Agreement and a Federalwide Assurance (FWA) may also be necessary from the cooperating institution. A FWA is a document which formalizes an institution’s commitment to protect human subjects and is required by any institution that participates in Federally supported human subject research. The UAMS Investigator should provide the UAMS IRB office contact information for the person at the collaborating institution with whom UAMS can work with to ensure that the appropriate agreements are in place for the collaborative research project.

The local IRB must approve all research studies conducted by CAVHS participants through the CAVHS Cooperative Studies program with other VA hospitals across the country.

Once all committee approvals (or submissions), grants and budgets information (this does not need to be finalized, just in process if applicable), and appropriate education certification has been documented, the PI can assemble the documents required for IRB review. While planning for the IRB review, it is a good time to prepare your submissions for the other institutional research bodies where the trial will be conducted.
The UAMS IRB requires that each new research application except those qualifying as “Exempt” will include a plan to assure the safety and welfare of its participants. The IRB (Full, Chair or Designee depending on nature of research) will review and approve these plans. The IRB will be the final arbiter of the type of plan needed.

The Principal Investigator may need to appoint a Data and Safety Monitor (DSM) or Data and Safety Monitoring Board (DSMB) for his or her study as appropriate for the size, complexity, and level of risk involved in the research.

Data Safety Monitoring Plan.

Some studies do not require a DSM or a DSMB. However, a detailed DSMP is required for all research that is not “Exempt” under Federal regulations. The level of detail in the plan should be based on the degree of risk entailed by the research participants. All DSMPs must contain at a minimum the following:

a. A description of how risks are minimized;

b. A description of how risks are reasonable in relation to anticipated benefits;

c. Identification of a DSM or DSMB;

d. A description of the general data safety monitoring plan;

e. A description of the plan to monitor progress and safety;

i. This may include a plan for safety review either by an assigned board, committee or monitor at predetermined intervals relevant to the complexity of the research;

ii. Depending on the complexity of the research, the plan may include assessments of data quality, timeliness, participant recruitment, accrual and retention.

f. A description of the plan to assure compliance with reporting of adverse events and/or unanticipated problems involving risk to participants or others. This may include:

i. A description of the process for detecting and reporting serious and unexpected adverse events and/or unanticipated problems involving risk to participants or others;

ii. A description of who will be monitoring and collecting the adverse events (e.g., PI, Research Nurse, etc.);

iii. Specification of who will be notified of an adverse event (e.g., IRB, NIH, FDA, PI, etc.)

iv. A reporting plan indicating the timing of reports;

v. A plan for annual reporting of adverse events if study longer than one year;

g. A description of the plan to assure suspensions of funded trials are reported to the grants program director; and

h. A description of the plan to assure data accuracy and protocol compliance.

For more information, see IRB Policy 7.8 (IRB Oversight of Activities for Data Safety Monitoring).
The PI must sign ALL communication with the IRB. Communication not signed by the PI will be returned.

IRB Protocol Submissions Requirements Using ARIA

The PI must submit their entire protocol to the IRB for review using ARIA (Automated Research Information Administrator).

For assistance with obtaining an ARIA username and password or for assistance with submitting protocol using ARIA, please contact the IRB office at 501-686-5667.

The documents required for IRB Protocol Submissions have to be uploaded in ARIA or you CANNOT submit. All documents need to be in a PDF Format. If you will be submitting protocols, you will need to purchase a copy of the software Adobe Acrobat.

NOTE: The latest copies of Adobe Acrobat and Adobe Approval are now available through UAMS IT Procurement for UAMS tagged PCs. To obtain more information or a copy of the software, please contact the Help Desk at (501) 686-8555.

- Information From The Following Documents Is Needed For Protocol Submissions Via ARIA:
  - HIPAA Authorization forms or Request a Waiver of HIPAA Authorization
  - A copy of the consent form (see Chapter 5 – Informed Consent and the Informed Consent Checklist on the IRB website) If a DHHS approved sample consent exists, provide it as well and justification for any substantial deviations.
  - A complete protocol containing details of the proposed research project, including:
    - Study background including scientific rationale and aims
    - Methods
    - A list of all procedures which are experimental
    - Anticipated risks and benefits to subjects and procedures to minimize risks
    - A discussion of human subject protection issues and methods
    - Number of subjects
    - Additional safeguards for the protection of vulnerable subject populations
    - Applicable confidentiality issues
    - Data analysis method
References

- A copy of the investigational drug or device brochure (from the sponsor) if the protocol requires the use of an investigational drug or device.
- A copy of the study Standard Operating Procedures (SOPs) if used in conducting the study.
- If the study is being done at the CAVHS, a copy of the VA forms you plan to submit there.
- If the study is being done at ACH, the review of protocol letter from Arkansas Children’s Hospital Research Institute (ACHRI).
- A copy of any survey or questionnaire to be used in the research.
- A copy of any advertisement to be used for subject recruitment.
- A simplified CV of the PI.
- Letters from appropriate committees, (i.e. Radiation Safety, PRMC, Biosafety Committees).
- If the study is funded by a grant, a copy of the entire grant application is required.
How To Submit A New Study Protocol Using ARIA

1. Access the ARIA website https://aria.uams.edu/default.lasso
2. Select PI LOGIN.
3. Enter your Username and Password.
4. Click on the Login button.
5. The “Welcome To ARIA” page appears.
6. Select Profile and edit the information if needed.
7. Click the Continue button to return to the main menu.
8. Select New Submission.
9. Select a Protocol Type:
   Is this a Behavioral, or Biomedical Study? Be sure to select the appropriate study type.
10. Click the Continue button.
    Complete the steps that follow by providing the requested information.
11. After all questions have been answered you will be able to “Add New Documents”. All documents MUST be PDFs.
12. Type in Title of Document, Type in Version #, Date.
13. Click the Add Document button.
14. Click the Add File button.
15. Select File.
16. Click the Browse button to find file on your computer.
17. Click the Upload File button.
18. Is this document acceptable? Yes or no
19. Click Yes.
20. Add all documents that are needed for this New Submission.
21. When you are finished adding documents, click the Continue button. Errors in the application will be identified and must be corrected to proceed.
22. Read the Investigator’s Agreement.
23. Click on the “I AGREE” button. It becomes an electronic signature.

You will receive an email acknowledgement that the IRB has received the online submission form.
CHAPTER 5

**Informed Consent**

Since the central requirement for human subjects research is that people participate voluntarily, the informed consent process is one of the most important parts of planning a research proposal. The process must assure that the potential subject understands the study and its risks and benefits and can certify his or her willingness to participate.

**A process - not a form**

**Informed Consent Document Elements**

**Informed Consent And Assent Documents**

**Signature/Date Sample**

**Exceptions From The standard Informed Consent Procedures**
A Process - Not A Form

The informed consent process begins with the presentation of the study to the subject and continues until the subject's study participation is completed. Obtaining the signature of the subject on an informed consent document is only one part of the process.

The informed consent process emphasizes that the subject is volunteering to participate in a research study and has the ability to withdraw from the study at any time without affecting their medical care. The process starts with exchange of information, usually in an interview setting. The setting and the tone of the interview must be non-coercive. A thorough explanation of all the study along with risks and benefits, and alternatives to participation is essential. The individual must be given an opportunity to ask questions and have those questions satisfactorily answered. The subject must be fully informed in order for consent to be truly voluntary. The informed consent document and other materials are used as a guide to this interview which is documented by the signing of the informed consent document along with a note in the permanent record.

Consent forms should include a statement that there may be unknown risks to the fetus if a woman becomes pregnant while participating in a clinical trial.

The IRB has the authority to observe or appoint a designee to observe the informed consent process and conduct of the IRB approved research process.

Informed Consent Document Elements

No Investigator may involve humans as subjects in research unless the Investigator has obtained the informed consent of that subject or the subjects’ legally authorized representative or a waiver has been granted by the IRB. An Investigator will seek informed consent only under circumstances that provide the prospective subject or the representative sufficient opportunity to consider whether or not to participate and that minimize the possibility of coercion or undue influence. The informed consent document must include the following:

- A clear and concise explanation of the research to be conducted and the procedures to be employed.
- Be written in language appropriate for the targeted subject population (e.g.; eighth grade reading level, English and foreign language versions for a multi-cultural study).
- Clear and precise language detailing all potential risks or discomfort and procedures to minimize such risks, duration of participation, and benefits of participation.
- A statement defining the right of the subject to withdraw at any time without affecting medical care.
- A statement describing alternatives to the proposed research activity, if any exist.
- A statement that the data/information will be kept confidential.
- A statement of whom to contact for answers to pertinent questions about the research and research subjects’ rights, and whom to contact in the event of a research-related injury to the subject.
• A statement that the subject is fully informed and agrees to participate on a purely voluntary basis.

❖ Informed Consent Document Elements Information

The IRB has the ability to waive all or a part of the informed consent requirements. For more information, see IRB Policy 15.3 (Waivers of Signed Informed Consent Documents and Waivers of Informed Consent Elements).

For a complete list of Informed Consent Document elements, see the web checklist or IRB Policy 15.1 (Informed Consent).

The IRB also requires specific elements to be included in each consent form in order to comply with federal, state and institutional regulations. Use the Investigator's Checklist for Informed Consent in preparing UAMS consent and assent forms prior to IRB submission. This can be found on the UAMS IRB website.

For more information, visit the CAVHS website at CENTRAL ARKANSAS VETERANS HEALTHCARE SYSTEM (CAVHS) website.

❖ Informed Consent And Assent Documents

The informed consent form for an adult must provide signature lines along with dates and time for subject, Principal Investigator (PI), person obtaining consent, and witness. However, the person obtaining consent cannot serve as the witness, although a study team member may serve as the witness. The person serving as the witness is not required to be present during the explanation of the study, but must be present for the signing of the consent document by the subject. The IRB requires the PI's signature on all subject informed consent documents. The PI may designate someone to explain the consent and does not have to be present when the subject signs the consent but must subsequently sign this document signifying acceptance of the responsibility for all aspects of the study with regards to the enrolled subject..

If children from 7-17 years of age are subjects, signature lines with date and time should also be provided for the child’s assent and for the parent(s) permission. If the IRB deems the risk of the study in children to be Pediatric Category 3 or 4, space for both parents’ signature must be available.

The PI must retain the original signed consent form document in the study file and provide a copy to the subject. The PI must retain copies of the completed consent forms for a period of at least three years following termination of the protocol. The IRB may request the PI to maintain a longer storage period for the executed consent form.

Each subject must be given a copy of the signed informed consent document. A copy of the subject’s informed consent must be placed in the medical records. Pharmacies at each institution may also require a copy of the signed informed consent and protocol before dispensing study drugs.
Additionally, the process of informed consent must be documented by an entry in the subject’s permanent or medical records. A progress note should be made that includes:

- The date the subject was entered into the study
- The title of the study
- The name of the Principal Investigator
- The name of the person obtaining the informed consent
- The subject had an opportunity to ask questions about the research and have those questions answered

Note: CAVHS has special requirements for documentation and filing of informed consent. The Investigator should consult the VA R & D Standard Operating Procedures for complete information.

**Signature/Date/Time Sample**

___________________________  _____________________  
Subject Date/Time

___________________________  _____________________  
Principal Investigator Date/Time

___________________________  _____________________  
Witness Date/Time

___________________________  _____________________  
Person Obtaining Consent Date/Time

The Investigator must retain the original signed consent form document in the study file and provide a copy to the subject.

If a pharmaceutical company commits to payment of any medical expenses resulting from research injury, the Investigator must furnish a letter, or section of the contract, from the pharmaceutical company to the IRB confirming that commitment. The letter should be signed and dated by a duly authorized official of the company. The letter and consent form must state the extent to which the payment of medical expenses, injuries, and other losses will be made and include any conditions for payment (e.g., refusal to pay prior to submission for payment by subject’s insurance carrier or other third party). If the company agrees to pay only after claims are submitted to the insurance carrier or other third party, the claim submission will indicate that the injury is the result of an adverse drug reaction as part of an investigational trial.
Each page of the consent form should be numbered and dated. (The date will change with each revision of the consent form.)

Exceptions From The Standard Informed Consent Procedures

Emergency Research Protocols Where Prospective Informed Consent is Waived

It is possible to have a protocol involving enrollment of subjects in life-threatening situations when a signed informed consent is not feasible prior to use of an investigational test article. 45 CFR 46.101(i) and 21 CFR 50.24 provide specific requirements that must be met by the Investigator who will conduct research in emergency research protocols. Both the Investigator and a second physician not otherwise participating in the clinical investigation must certify in writing all of the following:

• The subject is confronted by a life-threatening situation necessitating the use of the test article
• Informed Consent cannot be obtained because of an inability to communicate with, or obtain legally effective consent from the subject
• Time is not sufficient to obtain consent from the subject’s legal representative
• There is no available alternative method of approved or generally recognized therapy that provides an equal or greater likelihood of saving the life of the subject
• Risks and benefits of the experimental treatment are reasonable in light of what is known about the condition and risks and benefits of other therapies

Please refer to the “Special Situations” section of the Handbook that elaborates on IRB requirements for these conditions.

Waiver of Written Informed Consent

The IRB may waive the requirement for the Investigator to obtain a signed consent for some or all subjects [45 CFR 46.117(c)] if it finds that:

• The only record linking the subject to the research would be the consent document, and the principal risk to the subject is the potential harm resulting from a breach of confidentiality. In that event, each subject should be asked if he/she wishes to have documentation linking the subject with the research. The subject’s wishes will govern OR
• The research presents no more than a minimal risk of harm to subjects and involves no procedures for which written consent is normally required outside of the research context. In cases where the requirement of documentation is waived, the IRB may require that the Investigator provide the subject with a written statement regarding the research.

The Investigator may request the IRB’s ruling on waived consent at the time the protocol is submitted.
• **Waiver of the Requirement to Obtain Prospective Informed Consent From Subjects in Non-Emergency Research**

Federal regulations allow the IRB the ability to grant a waiver from the requirement to obtain any consent from research subjects in non-emergency research, but only under specific circumstances and only when the decision is made at a convened meeting.

If an Investigator believes neither written nor oral consent can be obtained from *any* subjects without jeopardizing the conduct of the project, arguments to support this position should be articulated in the application.

In order to grant a waiver, the IRB (Full Committee or Chair/Designee) must document that it believes the request meets the following criteria:

a) The research involves no more than minimal risk to the subjects
b) The waiver will not adversely affect the rights and welfare of the subjects
c) The research could not be practicably carried out without the waiver
d) Whenever appropriate, the subjects will be provided with additional pertinent information after participation.
CHAPTER 6

Continuing Review

Institutional Review Board review is an ongoing process, not a one-time step. Regular reevaluation ensures that research is conducted responsibly. Even in responsibly conducted studies, a one-time review is inadequate, since risks can really be understood only after research has begun, and since the regulations for human subjects research are constantly being refined as the risks and benefits are better understood. Unexpected developments in a project can raise questions about the conduct of the research, and new findings can raise questions about the project.

Continuing Review General Information

IRB Continuing Review Requirements Using ARIA

IRB Continuing Review Process

Notification of Investigators Following Continuing Review

How To View A Letter For Your Protocol

Continuing Review Summary Information
Continuing Review General Information

All full and expedited human use protocols approved by the IRB are subject to substantive continuing review. Studies classified as Exempt must submit an annual update. The Office for Human Research Protections (OHRP) and the FDA require periodic re-evaluation by the IRB of all approved research at intervals appropriate to the study's degree of risk.

Continuing Review must occur at least once per year and the IRB may require more frequent reviews. There is absolutely no grace period. If Continuing Review approval expires, the study no longer has approval. All interactions with subjects and/or their data must cease and the Investigator should immediately contact the IRB regarding the treatment of enrolled subjects.

The IRB may determine that the degree of risk warrants a more frequent review in order to protect human participants from harm. Some protocols can be reviewed on a quarterly or six-month review cycle, but the approval period will never exceed one year.

How Is The Continuing Review Date Determined?

DHHS regulations at 45 CFR 46.108(b) and 109(e) require, respectively, that (1) except when an expedited review procedure is used, each IRB must review proposed research at convened meetings at which a majority of the members of the IRB are present, including at least one member whose primary concerns are in nonscientific areas; and (2) an IRB must conduct continuing review of research at intervals appropriate to the degree of risk, but not less frequently than once per year. The IRB should decide the frequency of continuing review for each study protocol necessary to ensure the continued protection of the rights and welfare of research subjects.

IRB Continuing Review Requirements Using ARIA

Principal Investigators (PI’s) must submit their Continuing Reviews to the IRB using ARIA (Automated Research Information Administrator).

The mechanism for starting the continuing review process is through ARIA’s on-line continuing review module located at https://aria.uams.edu/default.lasso.

For step-by-step instructions on submitting Continuing Reviews, access the Continuing Review Submission Training Handout for ARIA Web Information System.

The documents required for Continuing Review must to be uploaded in ARIA. All documents need to be in a PDF Format. If you will be submitting protocols and continuing reviews, you will need to purchase a copy of the software Adobe Acrobat.

NOTE: The latest copies of Adobe Acrobat and Adobe Approval are now available through UAMS IT Procurement for UAMS tagged PCs. To obtain more information or a copy of the software, please contact the Help Desk at (501) 686-8555.

Regardless of continuing review by expedited or full IRB processes, the Investigator must provide the following:

a. A completed ARIA continuing review application;
b. Informed Consent Document – ARIA automatically loads the currently approved consent document, if applicable, into the CR form. The Investigator MUST verify the accuracy of what is listed and correct if inaccurate.

c. In addition to answering yes/no or providing a number in the ARIA form, a status report for all events since the last report should be submitted that includes a summary of the following:
   
i. All adverse events,
   
ii. Unanticipated problems involving risks to participants/others,
   
iii. Complaints about the research and resolution thereof
   
iv. Relevant recent literature
   
v. Interim findings
   
vi. Relevant multi-center trial reports
   
vii. Participant benefits
   
viii. Current risk-benefit assessment based on study results to date
   
ix. Gender, Minority status, and Vulnerable Population status and description
      (Example: Female, Caucasian, Prisoner)
      This may be provided in Step 10 of the form, or in a separately uploaded document.
   
x. Reports from Data Safety Monitoring or IND Monitoring Activities required in policy 7.8.

d. If an Investigator allows a study to expire before continuing review approval is received, the investigator must immediately provide the IRB with a list of current participants whose safety might be at risk by stopping research procedures. If the research involves CAVHS, the Investigator must also notify the R&D Committee Chair.

For more information, see IRB Policy 7.6 (Continuing Review).

❖ IRB Continuing Review Process

At the time of initial review, the convened IRB determines how often research projects should be re-evaluated based on the level of risk. Assessment of level of risk includes physical, psychological, social and economic factors. Federal regulations require IRB Continuing Review approval at least once per year. Most research projects are re-evaluated according to this schedule.

Protocols more likely to be reviewed at least every six months include:

a. Involvement of vulnerable populations;

b. Research conducted internationally;

c. The involvement of recombinant DNA or other types of gene transfer protocols;
d. The use of waiver of informed consent procedures, e.g. surrogate consent;

e. Classified research;

f. Research for which subjects would be exposed to additional risks, e.g. breach of confidentiality, continual non compliance with federal regulations, Phase 1 studies, disproportionate number or severity of SAEs;

g. Previous suspension of the researcher due to compliance, record-keeping or other concerns

h. Recommendations from other intra-institutional committees

The Principal Investigator is notified by electronic mail of the continuing review approvals expiration date for continuing review at the time the protocol is initially granted approval. Continuing review reports are required for all active research projects approved by the IRB even if all data analysis has been completed since the last approval unless the study has been closed by the IRB.

The continuing review expiration date may change from year to year. Each time the convened IRB conducts continuing review, the study calendar is reset to the date of the meeting.


Continuing Review reminder notices are sent via electronic mail to the PI three months before the continuing review expiration date. In addition, another email will be sent two months before the end date alerting PI’s to have the CRR submitted four weeks before the end date.

However, the PI remains ultimately responsible for obtaining continuing review, and should not depend solely on IRB notification as a prompt for submitting the Continuing Review Report (CRR) and request for renewal. Investigators are advised to submit Continuing Review Reports at least four weeks prior to expiration to allow sufficient time for processing the report prior to the project’s expiration.

It is important to remember that there is no grace period. Continuing Reviews do not lapse – they expire. If Continuing Review Approval expires, all study activity should cease (not just new subject enrollment) and the IRB should be contacted.

The IRB utilizes the Primary Reviewer system in conducting continuing reviews. A minimum of one reviewer will facilitate the review among the committee members. The Primary Reviewer and the entire committee will have access to the Continuing Review Report.

The Primary Reviewer will present criteria required for review to the convened IRB with discussion of the protocol before a vote for continuing approval can be made. The IRB will vote separately on each continuing review. The vote will be recorded in the meeting minutes.

Continuing review may be conducted by expedited review only where the study falls into one of the expedited review categories and is minimal risk. Expedited review may also be used for continuing review if a study has been closed to accrual and intervention has been completed, but the Investigator is still collecting follow-up data.
Continuing review rulings are as follows:

**Protocol approval:** Follows review of satisfactory information submitted by Investigator regarding an ongoing project.

**Protocol approval Deferred (Major or Minor):** The information submitted by the Investigator regarding an ongoing project is not sufficient for re-approval. Additional information from the Investigator is required. Minor revisions may be reviewed through the expedited process. Major revisions in the project as submitted must be addressed by the convened IRB. This information must be received as requested by the IRB.

**Protocol Suspended:** Suspension follows review of information submitted by Investigators regarding an ongoing project that addresses issues of concern or serious problems in risk/benefit analysis. Protocol enrollment and study procedures must stop until additional information can be reviewed by the convened IRB.

**IMPORTANT REMINDERS:**

Timely submission of continuing review reports (CRR) is the Investigator’s responsibility and is essential to the continuation of the study.

A copy of all continuing review reports (CRRs) and approval letters should be kept in the Investigator’s study regulatory file.

All protocols not approved by the IRB by the project’s continuing review expiration date are no longer approved. All new accrual must cease and all further subject (or data) interactions must cease unless specifically approved by the IRB due to subject safety concerns.

**Notification Of Investigators Following Continuing Review**

All of the committee’s action on the protocol’s continuing review submission will be posted on ARIA in the LETTERS section.

Once the PI views the information in the LETTERS section posted on the ARIA website for the protocol, the PI should make the required corrections, clarifications or modifications, and resubmit them to the IRB office via ARIA.

It is the PI’s responsibility to keep track of each Continuing Review submission and to check the ARIA website to know the current status of the protocol. Use the following steps to view a letter for your protocol:
How To View A Letter For Your Protocol

- Access the ARIA website at https://aria.uams.edu/default.lasso.
- Select PI LOGIN.
- Select the IRB # of the protocol you wish to view.
- The Protocol Detail screen appears with five options available:
  1. Documents
  2. Letters
  3. Adverse Events
  4. Continuing Reviews
  5. Modifications
- Select option 2, Letters.
- The Letters information appears with the following titles:
  Status
  IRB#
  Message Type
- Click on any of the above titles.
- The letter opens via Internet Explorer and allows you to print from the browser.

Continuing Review Summary Information

For studies where continuing review approval has expired and only upon PI request, the IRB will determine on a case-by-case basis if it is appropriate for safety reasons to allow continued interactions and/or interventions with currently enrolled subjects. A notice is sent to the PI. The study will be terminated 30 days after study suspension notification if no response has been received from the Investigator.

If the IRB’s review of a project requiring continuing review results in termination, a new IRB application may be required to continue with the research. No new subjects may be enrolled, all ongoing research activities must stop, and subjects currently participating should be notified that the study has been terminated. The regulations make no provision for any grace period extending the research beyond the date the CR expires.

Termination notices due to non-compliance with the federal regulations for continuing review will be sent to the PI, the Department Chair, and the Office of the Vice Chancellor for Academic Affairs and Research Administration (VCAA/RA). The IRB must also notify study sponsors, the FDA and OHRP (if the studies are government funded). If the study is done at CAVHS, the VA Research and Development Committee (VA R&D) along with the Office of Research Compliance (ORC) will be notified of termination.
CHAPTER 7

Amending A Protocol

This section details the steps involving amending a research protocol.

Protocol Amendments
Protocol Amendments

During the course of a research activity, the sponsor and Investigator may decide that elements of the research require modification. If an Investigator or sponsor finds it necessary to deviate in any way from an IRB approved protocol, consent forms, or eligibility requirements, an amendment or request in writing to the IRB must be submitted with the changes highlighted. If a change affects the approved consent form, it will be necessary to submit a revised consent with changes highlighted. New consent forms must have the version and date revised. The protocol amendments will be considered by the fully convened IRB or by the IRB Chair/Designee if the amendment is considered minor in nature.

Changes in the research may not occur until IRB approval of the amendment is received unless there is an immediate threat to the health of the participant. If such a situation were to occur, it would be the PI’s responsibility to immediately report the event to the IRB as a protocol deviation and serve notice that an amendment to the protocol will be forthcoming.

Major changes to an existing protocol, such as a change in the aim of the study, or the degree of risk to the subject may require that a new protocol be submitted (usually with a new title) and the old protocol be closed.

After IRB approval of the protocol amendment, a copy of the approval letter should be sent to the sponsor by the Investigator. The VA R & D Committee will also require copies of protocol amendment approval for research at CAVHS. A copy of the submission, approval letters, and amendments should be kept in the study’s regulatory files.

Any changes or amendments to an already approved protocol must be submitted for review and approval by the IRB prior to initiation unless a serious safety issue exists.
CHAPTER 8

Research Record-Keeping And Reporting

This section details the information involving research record-keeping and reporting.

ARIA Information

Record-Keeping Responsibilities Of The Principal Investigator

Investigator’s Responsibilities For Test Article Accountability

Subject Information Regarding Investigational Drugs Or Devices

Investigator IRB Reporting Responsibilities

Change in Principal Investigator

Communicating With Subjects

Reporting Responsibilities Of The Principal Investigator To The IRB

Adverse Event Reporting

How To Report A Death Or Serious Adverse Event

Reporting Protocol Deviations

Reporting Protocol Violations

Reporting Notification Of Pending Audits Or Inquiries

Reporting to Appropriate Federal Oversight Bodies, Institutional Officials and Research Sponsors
### ARIA Information

All reporting (local, non-local, and death) must be submitted through the Automated Research Information Administrator’s (ARIA) on-line module located at [https://aria.uams.edu](https://aria.uams.edu)

For assistance with obtaining an ARIA username and password, please contact the IRB Office at 501-686-5667.

### Record-Keeping Responsibilities Of The Principal Investigator (PI)

Proper record keeping is integral to the validity and reliability of data collected during research trials. It is the PI’s responsibility to oversee the general organization and design of study records, both paper and electronic, and assure that all records are authentic. All data recorded on study recording forms and procedures performed should be supported by documents filed in the study file. Each study involving human subjects must have a log listing those enrolled and those who were approached to enter the study with identifying information. Identifying information can be encrypted.

The PI is also responsible for the proper organization of regulatory documents: such as protocols, protocol amendments, IRB submissions, CRR and approval letters, reports to all appropriate entities on adverse events, deaths, protocol violations and deviations.

Each study should have the following general records:

<table>
<thead>
<tr>
<th>Regulatory</th>
<th>Individual Subject Files</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subject Log</td>
<td>Original signed informed consent form</td>
</tr>
<tr>
<td>Copies of all IRB correspondence</td>
<td>Copies of study case recording/reporting forms (CRFs)</td>
</tr>
<tr>
<td>Approved Protocol</td>
<td>Subject medical record number and emergency contact information</td>
</tr>
<tr>
<td>Approved Consent Form</td>
<td>Supporting Documentation for: *</td>
</tr>
<tr>
<td>IRB Approval Letters</td>
<td>Inclusion/Exclusion criteria</td>
</tr>
<tr>
<td>Other Institutional approvals</td>
<td>Results of tests or procedures</td>
</tr>
<tr>
<td>Continuing review reports</td>
<td>Adverse events</td>
</tr>
<tr>
<td>Investigator’s Brochure</td>
<td>Deaths</td>
</tr>
<tr>
<td>Correspondence with sponsors</td>
<td>Communications with subject and follow up exams</td>
</tr>
<tr>
<td>Special Committee approvals</td>
<td>Protocol Violations</td>
</tr>
<tr>
<td>Study Standard Operating Procedures</td>
<td>Protocol Deviations</td>
</tr>
<tr>
<td>Sample questionnaires</td>
<td></td>
</tr>
<tr>
<td>Sample study forms with instructions</td>
<td></td>
</tr>
<tr>
<td>Reports of unanticipated problems involving risks to participants or others</td>
<td></td>
</tr>
<tr>
<td>Drug Accountability Records</td>
<td></td>
</tr>
</tbody>
</table>

UAMS Institutional Review Board (IRB) Investigators Handbook
Drugs/Equipment Shipping Receipts  
Data Safety Monitoring Reports (if applicable)

* Completed study recording forms are not considered supporting documentation. Additional records are needed.

Example: A lab value recorded on a study form must be supported by a clinical laboratory report of that test.

These records and any other that assists in collection of data must be consistently maintained. The PI may delegate elements of record keeping activities, but remains responsible for accuracy, authenticity, validity and completeness of all study records. Investigators should consult each specific protocol for the length of time that study records should be maintained.

If the study is being carried out at Central Arkansas Veterans Healthcare System (CAVHS), the Investigator has additional record keeping responsibilities. A complete list can be obtained from the VA Research and Development (R & D) Committee. For more information regarding VA submissions, contact the CAVHS Administrative Office at 501-257-4816.

- **Investigator’s Responsibilities For Test Article Accountability**

A pharmaceutical product, device or any other investigational product must be received, maintained, stored, inventoried and accounted for by the Investigator according to Federal Guidelines. The Investigator is responsible for the control and documentation of all test articles. If investigational drugs are involved in a study, shipment from the sponsor must be coordinated through the institution’s pharmacy. Sponsors may ship investigational drugs directly to a subject only in very rare circumstances. It is also against federal law for anyone other than the sponsor to send investigational drugs or devices to an Investigator. Arrangements with the pharmacy for the receipt of all investigational drugs should be completed prior to submitting the protocol for approval.

Example: You are new to the institution and plan to continue your study of implantable catheters. The protocol has received IRB approval. You must receive a new batch of catheters from the sponsor. You cannot obtain them from your previous workplace.

The Investigator must assure the maintenance of a drug or device record that is current and includes the following:

- Date of delivery and shipping Invoice including name and address of consignee, type and quantity of drug or device and date of shipment
- Inventory log, with unique code numbers, reflecting use by each subject
- Location and environmental conditions of storage
- Security of storage (tamper-proof)
- Expiration dates, if applicable of drugs and devices
- Records validating that appropriate personnel used the drug or device according to protocol

*For Investigational Drugs*: Documentation should include the amount of drug that was dispensed, unused by the subject, wasted by the research staff and returned to the pharmaceutical company.
Documentation records must also reflect subject identification, the reason for waste or return, and batch or lot numbers of returned materials.

For Investigational Devices: Documentation of the device used, including batch number, lot or identification number, subject identification, patient materials provided, devices returned to company and malfunctioning devices. Investigators must submit an “Acknowledgement of Investigator Responsibility for Investigational Devices” form with ARIA Submission. Form can be found at the IRB website.

The Investigator must assure that test articles are administered or dispensed under his or her personal supervision or the supervision of the appropriate competent personnel. Arkansas State Law requires that only a physician or pharmacist may dispense drugs. An Investigator shall not supply a test article to any other person for administration or to use upon subjects for any other purpose, without the prior authorization of the sponsor [CFR 21 812.110 (c)].

If the test article is a controlled substance, the Investigator must assure that it is appropriately stored, dispensed and accounted for and take reasonable precautions against the drug’s diversion. Controlled substances must be administered only by those legally allowed to do so.

Unused test articles must be returned to the sponsor. Documentation of the shipment should be retained with the drug/device record. For studies conducted at the VA, the disposal of unused articles should be done through the pharmacy after a letter of direction sent by the PI.

Subject Information Regarding Investigational Drugs Or Devices

The Investigator or his designee must explain the correct use of the investigational product to each subject. Subjects should be followed up periodically to assure that they are using the products correctly. Additionally, sponsors often include device product identifiers, including lot numbers. These should be given to the subject. A copy of lot numbers or unique identifiers should be recorded in each subject’s medical record. Drug information must be recorded in the subject’s drug dispensing log.

Investigator IRB Reporting Responsibilities

Communication between the Investigator and the IRB is critical to the Institution’s ability to conduct research using human subjects. Timely communications from the PI and appropriate guidance by the IRB and the institution where the research is being performed is necessary for the protection of the subject, the maintenance of research compliance and the elevation of the quality of the research.

Change in Principal Investigator

The IRB must be notified within 30 days of a change in the principal investigator. When changing investigators, please submit the following:

1. Protocol Amendment/Modification Form through ARIA.
2. A letter from the principal investigator indicating the change in responsibility.
3. A letter from the new investigator accepting the responsibility for the research, and the new investigator’s CV if not already part of the study file.

4. Revised protocol, consent forms, HIPAA authorizations or advertisements, as applicable.

5. Revise FDA Form 1572 if applicable.

Any IRB project associated with a Principal Investigator (PI) who has left the University of Arkansas for Medical Sciences, or other institutions using the UAMS IRB as the IRB of record, cannot continue without modification. These projects must be closed or a new PI must be signed to take full responsibility for the project and the subjects enrolled in the project. If the study cannot be closed because of safety issues related to participant involvement, it is mandatory that a local, affiliated investigator be named as PI.

If a significant difference in the background, training and expertise exists between the two PIs, the IRB may consider the change in PI to be a major revision, requiring a full Board review before the change can be officially implemented. A change in sub-investigators must also be reported to the IRB. It is the responsibility of the PI to notify the IRB when a sub-investigator is dropped from a study and when a new sub-investigator joins an IRB-approved project. Sub-investigator changes are considered minor revisions, but must also be approved before the change can be implemented.

Communicating With Subjects

Serious adverse events, deaths, changes in protocol and other new information regarding a study may need to be reported to subjects. Letters of this nature must be approved by IRB prior to mailing.

Reporting Responsibilities Of The Principal Investigator To The IRB

The table below describes what investigators must report to the IRB:

<table>
<thead>
<tr>
<th>Investigator Must Report:</th>
<th>Time Frame for Reporting:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Serious, Unanticipated and Related events</td>
<td><strong>Within 10 days</strong> of the event</td>
</tr>
</tbody>
</table>
| • Deaths | **Immediately, if the death is related to the research.**  
For subjects off protocol whose death is not related to the study, report death with the next continuing review. |
| • Protocol deviations | **Within 10 days**, if the deviation represents a significant alteration in the approved protocol and /or if it affects the safety or welfare of the subject.  
Otherwise, report with the next continuing review. |
Investigator Must Report:

<table>
<thead>
<tr>
<th>Time Frame for Reporting:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Protocol violations</strong></td>
</tr>
<tr>
<td>Within 10 days, if the violation represents a significant alteration in the approved protocol and /or if it affects the safety or welfare of the subject. Otherwise report with the next continuing review.</td>
</tr>
<tr>
<td><strong>Changes to approved research procedures or protocols (amendments)</strong></td>
</tr>
<tr>
<td>Prior to implementation</td>
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<tr>
<td><strong>Noncompliance with conducting of research protocols</strong></td>
</tr>
<tr>
<td>Within 10 days of discovery of noncompliance.</td>
</tr>
<tr>
<td><strong>Restrictions, suspension or termination of study by the sponsor or principal investigator by funding source, regulatory body or administration</strong></td>
</tr>
<tr>
<td>Within 10 days of notification of restrictions or suspension.</td>
</tr>
<tr>
<td><strong>Notifications of Pending Audits or Inquires by external bodies (e.g. sponsors, FDA, NCI, or NIH). Investigators are required to report any communication from a federal or state department or agency or sponsor that questions the conduct of research or suggests an impending inquiry, audit or investigation. The PI must inform both the IRB and the Office of Research Compliance</strong></td>
</tr>
<tr>
<td>Within 10 days of notification of audit or inquiry.</td>
</tr>
</tbody>
</table>

For more information, see IRB Policy 10.2.

**Adverse Event Reporting**

Your responsibility as a Principal Investigator includes the prompt reporting to the IRB of serious, unexpected and related events associated with the use of either investigational drugs or devices or other research procedures. A death of a subject that is not protocol related and part of long-term follow up (e.g. following until death on oncology protocols) should be reported with continuing review. Reporting to the IRB does not substitute for a Principal Investigators’ responsibility of reporting to a Sponsor.

A serious adverse event is any adverse experience occurring at any dose that:
• Results in death.
• Is life-threatening (places the subject at immediate risk of death from the experience as it occurred).
• Results in a persistent or significant disability/incapacity.
• Results in or prolongs an existing in subject hospitalization (even if in the hospitalization is a precautionary measure for observation).
• Is a congenital anomaly/birth defect in offspring of subjects taking the product, regardless of time to diagnosis.
• Represents any other important medical event that, based upon appropriate medical judgment, may jeopardize the participant and may require medical or surgical intervention to prevent one of the outcomes listed above.

You **MUST** report any death to the IRB office if:

• Protocol requires reporting of the death to the study sponsor or the FDA.
• The subject was being actively treated on an approved research protocol at the time of death.
• During the course of long-term follow up after completion of the experimental (i.e. active treatment) portion of an approved study protocol, the Investigator becomes aware of the death of the research subject.

You do not need to report the death of a subject if:

• The study protocol has been officially closed and a final report has been received and accepted by the IRB.

**How To Report A Death Or Serious Adverse Event**

The Investigator reports deaths or serious adverse events by completing and submitting the Serious Adverse Event Reporting Form online on ARIA. The PI must also submit all SAE reports (local, non-local, death) online in the report format given and upload the documents at the prompt. In addition, the PI must also include any correspondence sent to the sponsor or FDA regarding the event along with any additional information related to the study. Remember to send a copy of the form and your report to your institution’s research committees, e.g. VA Research & Development Committee.

For more information, see [IRB Policy 10.2 (Unanticipated Problems Involving Risks to Participants or Others – Investigator Reporting Requirements and IRB Actions)](IRB-Policy-10.2).

**Reporting Protocol Deviations**

Protocol Deviations are study events that are not covered under the approved research protocol, which represent a failure to comply with the protocol. *Example: A subject does not have the kidney biopsy, which is required six months after beginning transplant medication because she is in the ICU.* The PI should report a protocol deviation to the IRB immediately, if it represents a significant alteration in the approved written protocol and/or affects the safety and welfare of the subject. Otherwise, report
with the next continuing review. Note: Protocol deviations are often referred to as “protocol exceptions”. For the purpose of IRB reporting, the two are the same.

❖ Reporting Protocol Violations

Protocol Violations are those events clearly occurring outside of the approved research activity, which also represent a failure to comply with the protocol. The terms protocol deviation and protocol violation are similar, although a protocol violation refers to more serious non-compliance, which more often leads to exclusion of subjects from eligibility analysis or their discontinuation from the study.

Example: Enrolling a subject in a cancer study when the subject has no histological or clinically proven cancer is considered a protocol violation when a tissue diagnosis of cancer is a protocol inclusion criterion.

The PI must report protocol violations to the IRB, the sponsor, and all participating institutions. The report must be issued immediately if the health of welfare of the subject was jeopardized. Otherwise, report with the next continuing review.

❖ Reporting Notification Of Pending Audits Or Inquiries

Investigators conducting research involving human subjects are required to report ANY COMMUNICATION from a federal or state department or agency or sponsor that questions the conduct of research or suggests an impending inquiry audit or investigation. The Principal Investigator (PI) MUST submit through ARIA a detailed description of the proposed inquiry within 10 days from the notification of the Investigator. It is strongly suggested that the PI first inform the IRB and the Office of Research Compliance (ORC) by phone or electronic mail immediately upon notification of inquiry.

For more information, see IRB Policy 10.2 (Principal Investigator Reporting Requirements).

❖ Reporting to Appropriate Federal Oversight Bodies, Institutional Officials and Research Sponsors

It is the responsibility of the UAMS IRB to assure that reporting required under appropriate regulations, the terms of the Federal Wide Assurance, and IRB Policy is accomplished. When required reporting includes an affiliate organization utilizing the UAMS IRB, the mechanisms will be outlined in an agreement with each affiliate.

The IRB will assure the following issues are reported to appropriate agencies, institutional officials and the convened IRB within a reasonable timeframe from the final determination of the convened committee:

1. Any unanticipated problems involving risk to participants or others
2. Any serious or continuing non-compliance with this policy or the requirements or determinations of the IRB
3. Any suspension or termination IRB approval by the convened committee

For more information, see IRB Policy 2.6 (Reporting to Appropriate Federal Oversight Bodies, Institutional Officials and Research Sponsors).
Changing Study Protocol/Modifications to Previously Approved Research

All major and minor amendments or revisions must be submitted to the IRB for approval. The IRB Chair or his or her designee shall be the only one to determine as to whether an amendment is major or minor, based on degree of risk involved in the change.

The Investigator will do the following:

Make all amendment or modification requests through ARIA. Each modification will include:

1. Description of the changes;
2. Reason for the change;
3. Investigator’s opinion as to impact of change on study and on participants; and
4. Whether or not changes are needed to the consent form.

5. All documents, including but not limited to consents, protocols, recruitment materials, and Form 1572s, to be modified. If a sponsor or a granting agency has requested the amendment, a copy of the communication from the sponsor, as well as a copy of the amendment and/or the amended protocol should also be included. If the change affects the consent, provide both a tracked and a clean document.

Note: The IRB reserves the right to defer review if the changes are not highlighted or tracked on the document to be revised. If a document is received from a sponsor where tracking changes is not possible then an outline of the protocol changes must be provided.

No change should be implemented until IRB approval, and as applicable Sponsor approval, is received. The only exception is a change necessary to eliminate apparent immediate hazards to the research participants. In such cases, the Investigator will promptly inform the IRB, and as applicable the Sponsor, of the implemented change.
CHAPTER 9

Emergency Situations

This section gives information about emergency use of an investigational drug or Biologic, and emergency use of an Unapproved Medical Device.

[Emergency Use of an Investigational Drug or Biologic]

[Emergency Use of an Investigational Device]
Emergency Use of an Investigational Drug or Biologic

The purpose of this section of the handbook is to explain the limited circumstances where prior IRB approval is not required in the emergency use of an investigational drug or biologic.

Emergency Use means the use of a test article on a human subject in a life-threatening situation in which no standard acceptable treatment is available, and in which there is not sufficient time to obtain IRB approval.

Test Article. A test article is defined as any drug, biological product or medical device for human use, human food additive, color additive, electronic product, or any other article subject to regulation under the act or under sections 351 and 354-360F of the Public Health Service Act. As used hereafter, it shall only apply to investigational drugs or biological products. Emergency Use of a Medical Device is addressed in Policy 18.4.

Life Threatening. Life threatening includes the scope of both life threatening and severely debilitating, as defined below:

Life threatening means diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted and diseases or conditions with potentially fatal outcomes, where the end point of clinical trial analysis is survival. The criteria for life threatening do not require the condition to be immediately life threatening or to immediately result in death. Rather, the subjects must be in a life-threatening situation requiring intervention before review at a convened meeting of the IRB is feasible.

Severely debilitating means diseases or conditions that cause major irreversible morbidity. Examples of severely debilitating conditions include blindness, loss of arm, leg, hand or foot, loss of hearing, paralysis or stroke.

The IRB acknowledges that there will be certain limited circumstances where IRB approval will not be obtainable prior to the first use of a test article. FDA requirements for emergency use must be met, and the IRB requires prior notification of test article use. The IRB will acknowledge this one time use and require a follow up report. Any subsequent use of the test article will require full IRB review and approval prior to use. However, FDA acknowledges that it would be inappropriate to deny emergency treatment to a second individual if the only obstacle is that the IRB has not had time to convene a meeting.

Under FDA regulations emergency use of a test article is considered research. Under DHHS regulations emergency use of a test article is not research because it is not a systematic investigation designed to generate or contribute to generalizable knowledge. To maintain this distinction data from an emergency use cannot be used in any report of a prospectively conceived research activity.
The Principal Investigator will do the following:

- Obtain an IND (Investigational New Drug) number from the manufacturer, if possible, or if the manufacturer elects not to name the PI on the IND, the PI should then contact the FDA directly for an IND or obtain evidence of an IND Exemption.

- Notify the IRB, verbally, when a situation arises that calls for the emergency use of an investigational drug or biologic without an approved study protocol to obtain a determination from the IRB chair that the situation meets the regulatory requirements for an emergency use, and submit a letter to the IRB stating the following:
  - a. The participant was in a life-threatening situation
  - b. There is no standard acceptable treatment available
  - c. There is not sufficient time to obtain IRB approval.
  - d. The diagnosis, test article to be used and proposed use, and hospital.

- Obtain the consent of the participant or the legally authorized representative of the participant unless the PI and a physician who is not otherwise participating in the clinical investigation both make all of the following assurances:
  - a. Participant in a life threatening situation
  - b. All other available treatments are either unproven or unsatisfactory
  - c. Participant unable to give consent due to their medical condition
  - d. There is no time to obtain consent from LAR

- If in the PI’s opinion, immediate use of the test article is necessary to save the participant’s life and time does not permit seeking the opinion of a physician not otherwise involved, the PI should make the above determinations and proceed with the use.

- Within 5 days of the use of test article, the PI should submit a follow up report to the IRB that includes
  - a. Name of test article used, detailed conditions of use and date of IRB verbal acknowledgement
  - b. Date, time and location of use
  - c. Participant’s diagnosis and outcome if known
  - d. Any adverse events or unanticipated problems
  - e. Copy of the signed informed consent OR physician’s assurance as provided for above.

- Evaluate the likelihood of needing to use the test article again. If additional use is anticipated, immediately submit protocol and consent for full IRB review under separate ARIA submission.
The IRB Chair or Vice Chair will do the following:

- Evaluate the Investigator’s notice of intent to use a test article under these guidelines to determine whether FDA regulatory requirements are met.
- Request the information listed above, assessment of consent process, or any other materials that will aid in the evaluation.
- Provide initial verbal acknowledgement and shortly thereafter, written acknowledgement, through ARIA, of intent to use test article.
- Review the follow-up report and arrange for full committee notification on next available agenda.

† Emergency Use of an Investigational Device

The purpose of this section of the handbook is to explain the limited circumstances where prior IRB approval is not required in the emergency use of an unapproved investigational device.

Emergency Use means the use of a test article on a human subject in a life-threatening situation in which no standard acceptable treatment is available, and in which there is not sufficient time to obtain IRB approval.

Life Threatening. Life threatening includes the scope of both life threatening and severely debilitating, as defined below:

Life threatening means diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted and diseases or conditions with potentially fatal outcomes, where the end point of clinical trial analysis is survival. The criteria for life threatening do not require the condition to be immediately life threatening or to immediately result in death. Rather, the subjects must be in a life-threatening situation requiring intervention before review at a convened meeting of the IRB is feasible.

Severely debilitating means diseases or conditions that cause major irreversible morbidity. Examples of severely debilitating conditions include blindness, loss of arm, leg, hand or foot, loss of hearing, paralysis or stroke.

Test Article: A test article is defined as any drug, biological product or medical device for human use, human food additive, color additive, electronic product, or any other article subject to regulation under the act or under sections 351 and 354-360F of the Public Health Service Act. As used hereafter, it shall only apply to unapproved investigational medical devices. Emergency Use of Drugs or Biological Products are addressed in Policy 18.3.

The IRB acknowledges that there will be certain limited circumstances where IRB approval will not be obtainable prior to the first use of an unapproved investigational device. FDA requirements for emergency use must be met, and the IRB requires prior notification of the use. The IRB will acknowledge this one time use and require a follow up report. Any subsequent use of the test article will require full IRB review and approval prior to use, and an approved IDE.
Under FDA regulations emergency use of a test article is considered research. Under DHHS regulations emergency use of a test article is not research because it is not a systematic investigation designed to generate or contribute to generalizable knowledge. To maintain this distinction data from an emergency use cannot be used in any report of a prospectively conceived research activity.

The Principal Investigator will do the following:

- Determine whether device can be used under manufacturer’s IDE or be able to justify to FDA that all emergency requirements are met.

- Notify the IRB, verbally, when a situation arises that calls for the emergency use of an unapproved investigational device without an approved study protocol to obtain a determination from the IRB chair that the situation meets the regulatory requirements for an emergency use, and submit a letter to the IRB stating the following:
  a. The participant was in a life-threatening situation
  b. There is no standard acceptable treatment available
  c. There is not sufficient time to obtain IRB or FDA approval.
  d. The diagnosis, test article to be used and proposed use, and hospital.
  e. Assess the potential for benefits and have substantial reason to believe the benefits will exist
  f. Assure the IRB that an emergency actually exists and decision is based on that and not that the IDE approval process takes more time than available.

- Assure the IRB that the device manufacturer will notify the FDA of the emergency after shipping of the device. An unapproved device may not be shipped in anticipation of an emergency.

- Obtain the consent of the participant or the legally authorized representative of the participant unless the PI and a physician who is not otherwise participating in the clinical investigation both make all of the following assurances:
  a. Participant in a life threatening situation
  b. All other available treatments are either unproven or unsatisfactory
  c. Participant unable to give consent due to their medical condition
  d. There is no time to obtain consent from LAR
• If in the PI’s opinion, immediate use of the test article is necessary to save the participant’s life and time does not permit seeking the opinion of a physician not otherwise involved, the PI should make the above determinations and proceed with the use.

• Within 5 days of the use of test article, the PI should submit a follow up report to the IRB that includes
  a. Name of test article used, detailed conditions of use and date of IRB verbal acknowledgement
  b. Date, time and location of use
  c. Participant’s diagnosis and outcome if known
  d. Any adverse events or unanticipated problems
  e. Copy of the signed informed consent OR physician’s assurance as described above

• Evaluate the likelihood of needing to use the test article again. If additional use is anticipated, immediately submit protocol, consent and approved IDE for full IRB review under separate ARIA submission. If IDE application is disapproved by the FDA, the device cannot be used even in an emergency.

The IRB Chair or Vice Chair will do the following:

• Evaluate the Investigator’s notice of intent to use a test article under these guidelines to determine whether FDA regulatory requirements are met.

• Request the information listed above, assessment of consent process, or any other materials that will aid in the evaluation.

• Provide initial verbal acknowledgement and shortly thereafter, written acknowledgement, through ARIA, of intent to use test article.

• Review the follow-up report and arrange for full committee notification on next available agenda.
 Procedures during business hours

If the need for emergency use arises during the business day, the procedure to secure a waiver is as follows:

- The physician notifies the IRB office by telephone of a pending request for emergency use.
- The IRB administrative staff refers the physician to the IRB chair, or to a physician designated by the chair, to secure oral approval.
- Within five working days of the request, the physician provides the IRB office with written documentation of the oral approval, a copy of the unsigned consent form used to document informed consent of the subject, and a report of the experience.
- The IRB provides the physician with written confirmation of its approval. This should be maintained with the physician's records.

Many drug companies require IRB certification of approval to release drugs or biologics. The Investigator is responsible for the paperwork required by sponsors, drug companies, and the FDA.

 Procedures outside of business hours

If the need for emergency use arises when the IRB office is not open, the physician should:

- Secure approval, or agreement, from another physician who is not involved in the treatment of this particular patient,
- Alert the IRB office of the intended use,
- Report the action to the IRB office in writing within five working days.

Please note: Neither the common rule or the FDA regulations provide for expedited IRB approval in emergency situations. Therefore “interim”, “compassionate”, “temporary” or other terms for an expedited approval process are not authorized. The IRB must either convene and give “full board” approval of the emergency use or, if it is not possible to convene a quorum with the time available, the use may proceed without IRB Approval. When this situation exists, the IRB may issue an acknowledgement letter that they have been made aware of the use.
CHAPTER 10

Genetic Research

This section deals with genetic research.

Genetic Research
Genetic Research

The greatest risk to subjects participating in genetic research is the inappropriate release of personal and private information. Therefore, concerns for how Investigators will maintain the confidentiality of the data and specimens collected during the conduct of the study is a primary concern to the IRB.

The protocol and informed consent should address the following points:

- Study information is coded and personal identifiers maintained securely
- Consent forms include information about who will receive the data derived (e.g. the subject, family members, non-participation family members, family physician, other Investigators)
- Information as to whether clinically relevant information may be uncovered during the course of the study and whether subjects will be given the opportunity to decline receiving this information
- If children are to be research participants, how will permission be obtained from parents, how will assent be obtained from children and how will data be handled
- Participants may derive no benefit from participation.
- Study data should not be recorded in the subject’s medical record; separate research records with controlled access are preferred.
- Whether there will be any possibility of individually identifying subjects
- Inform subjects of any special risks associated with their participation (e.g. changes in family relationships, risks to privacy, confidentiality, insurability, employability, immigration status, and paternity suits)
- Indicate if general study results will be made available to subjects
- Whether genetic counseling will be made available and who will pay for this counseling
- Length of time in maintaining specimens (limited, indefinitely) and/or discarding specimens
- Subjects’ wishes to be re-contacted if clinically relevant information is developed
- If the Investigator intends to share specimens acquired during the research with other Investigators, this information must be included in the consent form and participants given the choice whether they are willing to permit this or not
- Should there be a potential commercial value derived from the research, the subject must be informed as to whether they will be asked to waive any rights or control over the tissue so used
- If the research involves the manufacture of a drug or biologic that is to be administered as a part of research, the Investigator should follow the 21CFR 210 “Good Manufacturing Practices” when required.
CHAPTER 11

Investigational Drugs and Medical Devices

This section concerns investigational drugs and medical devices.

Using Investigational New Drugs
Using Investigational New Devices
Use Of Medical Devices In Research Studies
Studies Involving Devices Known To Be Of Significant Risk
IRB’s Role In Distinguishing Between SR and NSR Device Studies
Investigator’s Responsibilities Related To Investigational Devices
Studies Of Devices With The FDA 510K Designation
Emergency Use Of Investigational Devices
Humanitarian Use Devices (HUD) Or Custom Devices
Investigational Devices That May Be Eligible For Exemption
Using investigational new drugs

Researchers who employ a test article classified by the Food and Drug Administration as an investigational new drug must assure the IRB that they are complying with the FDA's IND regulations (21 CFR 312). The IND number assigned to the test article must be filed with the IRB when the application for review is submitted.

Experimental drugs used in humans require an IND number if they are used to develop information about their safety or efficacy.

Approved, marketed drugs may also require an IND, if proposed use is:
- Different from its previously FDA-approved use,
- Administered by an unapproved route or method of delivery, or
- An altered dosage form,
- Shipped by interstate commerce in order to conduct a clinical trial.

The FDA has published several exemptions to the IND requirements. Roughly, a clinical investigation may be exempted from the IND requirements if the drug is lawfully marketed in the U.S. and all the following apply:
- The results will not be reported to the FDA to support a new indication for use nor to support any other significant change in the labeling of the drug;
- The investigation will not be used to support a significant change in the advertising of a prescription drug that is already on the market;
- The investigation does not involve a route of administration, dosage level, use in a patient population, or other factor that significantly increases the risks (or decreases the acceptability of the risks) associated with the use of the drug product;
- The investigation is conducted in compliance with the requirements for institutional review set forth in Part 56 and with the requirements for informed consent set forth in Part 50; and
- The investigation is conducted in compliance with the requirements of section 312.7, which concerns the promotion and sale of investigational drugs.

The IRB requires detailed discussion of all these points when an exemption from IND requirements is requested.

For more information on the criteria for studies classified as Exempt under the Federal Regulations, see IRB Policy 7.3 (Exempt Categories of Research) and for more information on Expedited Review, see IRB Policy 7.5 ( Expedited Review).

Using investigational new devices

Researchers who employ a significant risk device classified by the Food and Drug Administration as an investigational device must assure the IRB that they are complying with the FDA's Investigational Device Exemptions (IDE) regulations (21 CFR 812 or 814). The IDE number assigned to the test article must be filed with the IRB when the application for review is submitted.
Use Of Medical Devices In Research Studies

The IRB considers an investigational device to be one that is not currently marketed in the United States. According to 21 CFR 812, two types of device studies exist. These types are “significant risk” (SR) and “nonsignificant risk” (NSR). An SR device is defined as “a study of a device that presents a potential for serious risk to the health, safety, or welfare of a subject and (1) is an implant; or (2) is used in supporting or sustaining human life; or (3) is of substantial importance in diagnosing, curing, mitigating or treating disease, or otherwise prevents impairment of human health; or (4) otherwise presents a potential for serious risk to the health, safety, or welfare of a subject.” An NSR device study is defined as, “one that does not meet the definition for a significant risk study”.

NSR is not to be confused with the term “minimal risk” and studies of this type are not eligible for expedited review.

Studies Involving Devices Known To Be Of Significant Risk (SR)

Devices that are known to be SR require an IDE from the FDA. A list of known SRs can be found in the FDA website [www.fda.gov/cdrh/d861.html](http://www.fda.gov/cdrh/d861.html).

For studies involving SR devices, an IDE and appropriate information concerning the history of the device's use, proposed investigation plan, description of subject selection criteria and monitoring procedures must be included with the submission packet.

IRB’s Role In Distinguishing Between SR and NSR Device Studies

The IRB acts as the surrogate of the FDA with respect to the review and approval of NSR studies. If an Investigator OR sponsor proposes the use of a device it claims to be NSR, the IRB may agree and approve the study. If the IRB grants approval of an NSR device, the study may begin immediately and no IDE will be required.

If the IRB does not agree and believes the device poses significant risk, the study may not begin until both the IRB and the FDA approve the investigation. The IRB will notify the sponsor and Investigator of the SR decision. The Investigator will be required to obtain an IDE from the FDA. The study, if approved by IRB, will be conducted as a SR device trial.

Information that the IRB must review in making the determination between SR and NSR include the following (which should be provided with the initial protocol submission):

- Reports of prior investigations conducted with the device
- The proposed investigational plan
- Subject selection criteria
- Monitoring procedures planned for the study
- Sponsor’s risk assessment and rationale
- Sponsor’s statement detailing any other IRBs that have reviewed the proposed study and what determinations were made.
• Sponsor’s statement regarding any assessments of the device’s risk that may have been made by the FDA.

The IRB’s risk determination is based upon the proposed use of a device in an investigation and not the device alone. Factors that must be considered by the IRB when evaluating the risk of a device include:

• The nature of the harm that may result from the device
• Is the potential harm to subject’s life threatening?
• Could the potential harm to subjects result in permanent damage to or impairment of body structure or function?
• Could the use of the device necessitate medical or surgical intervention to prevent damage to body structure or function?
• If the subject must undergo a procedure as a part of the investigation study, e.g., a surgical procedure, the IRB must consider the potential harm from the procedure in addition to the potential harm of the device.

The FDA makes the ultimate decision in determining if a device study is SR or NSR. If it does not agree with IRB’s decision that a device study presents an NSR, an IDE application must be submitted to the FDA. Likewise, if a sponsor or Investigator requests an IDE from the FDA for a presumed SR device study, but the FDA classifies the study as NSR, the IDE application will be returned and the Investigator should resubmit the study to the IRB as an NSR with the returned application.

❖ Investigator's Responsibilities Related To Investigational Devices

21 CFR 812.110 states that Investigators may not obtain informed consent for the use of a device without first obtaining IRB and FDA approval. Investigators must assure that the device is placed under their direct supervision and supplied only to persons authorized to receive the device. If there is not a sponsor for an Investigational Device study, the Principal Investigator will be responsible for the internal monitoring and reporting functions of sponsors as listed in 21 CFR 812. The Investigator is also responsible for the control, disposal and record keeping related to investigational devices. Investigators are also responsible for maintaining the case histories of the subjects involved in investigational device trials. Investigational devices may not be used outside the supervision of the Investigator.

❖ Sponsor-Investigator's Responsibilities Related To Investigational New Drugs

It is the policy of the University of Arkansas for Medical Sciences (UAMS) Institutional Review Board (IRB) that all studies involving investigational drugs, agents, and/or biologics be reviewed and approved for use in accordance with Federal regulations and Institutional policies.

The IRB has the responsibility to evaluate all studies submitted by a Sponsor-Investigator, which involve the use of a drug substance, for compliance with 21 CFR 312, Investigational New Drug Application. There are at least three possible scenarios:
A. The Sponsor-Investigator already has applied for and/or received an IND under 21 CFR 312;

B. The Sponsor-Investigator has obtained a waiver of IND requirements from the FDA under 21 CFR 312.10; or

C. The Sponsor-Investigator has not determined the need for an IND for the study.

❖ Sponsor-Investigator Responsibilities

A. **IND Is Not Required**

   No further documentation is required of the Sponsor-Investigator; the ORC will issue a letter to the IRB.

B. **IND Waiver**

   If the Sponsor-Investigator has already obtained a Waiver for 21 CFR 312, the FDA letter granting the waiver must be submitted to the IRB. If they have not yet applied for a waiver, they must inform the IRB of their intent and submit the letter granting or denying the waiver to the IRB. If the waiver is denied, the Sponsor-Investigator must either apply for an IND as outlined in this document or withdraw the protocol from consideration by the IRB.

C. **IND Required**

   1. The Investigator will work with the ORC to develop an IND for submission to the FDA.
   2. The Sponsor-Investigator will provide the IRB with a copy of the FDA Acknowledgement Letter when received.
   3. The Sponsor-Investigator will notify the IRB and ORC when the 30-day waiting period is completed or if an FDA clinical hold has been placed on the IND.
   4. The Sponsor-Investigator will develop and institute Standard Operating Procedures (SOPs) for the conduct of the clinical investigation. Assurance will be given to the ORC that these SOPs are in place and an index of said SOPs will be submitted to the ORC.
   5. The Sponsor-Investigator will develop an IND monitoring plan (IRB Policy 7.8) and submit it to the IRB for their review and approval.
   6. The Sponsor-Investigator will consult with the Research Pharmacist to develop a cost impact statement, dispensing, control, and handling of the drug.
   7. The Sponsor-Investigator will consult with the ORC regarding the cGMPs and/or the cGTPs where applicable, and the GCPs.
Studies Of Devices With The FDA 510 K Designation

FDA regulations allow a manufacturer/sponsor to claim that a new device is substantially equivalent to models that FDA has already approved for marketing. Safety and efficacy testing of 510K devices, or use of 510K devices in clinical protocols, requires review by the IRB and approval before the study may begin. Application to the IRB should include verification of the device’s 510K status.

Emergency Use Of Investigational Devices

If, in the opinion of the Investigator, a situation exists where an investigational device is required to protect the life or physical well being of a subject in an emergency, outside of the investigational trial, the Investigator should contact the IRB Chairperson and request emergency acknowledgment. Emergency Use of Investigational Devices should be reported in writing to the sponsor and the IRB immediately by the Investigator. Ideally, communication with the sponsor and the IRB should occur before any test article is used outside of the research context. If the Investigator is the sponsor, he/she is required to notify the FDA of the emergency use within 5-working days of the event.

Humanitarian Use Devices (HUD) Or Custom Devices

Investigators who wish to use devices classified by the FDA as Custom or Humanitarian Use should consult the IRB office for guidance before using such a device or submitting a protocol.

Investigational Devices That May Be Eligible For Exemption

Some investigational devices are exempt from the FDA regulations. These included certain diagnostic devices, minor modifications of marketed devices or custom devices. Investigators should request guidance from the IRB if unsure of the device status before use.

All devices, including those exempt from FDA regulations, require review and approval by the IRB before use in patients or subjects.
CHAPTER 12

Research Involving Vulnerable Populations

Certain groups of human subjects are considered to be particularly vulnerable to coercion or undue influence in a research setting. These groups and their special attention during the research process are outlined in 45 CFR 46.111(b) and 21 CFR 56.111(b). The regulations identify additional requirements for review and approval of research involving fetuses, pregnant women, and human in vitro fertilization, 45 CFR 46 Subpart B, prisoners, 45 CFR 46 Subpart C, and children, 45 CFR 46 Subpart D.

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Background Information

The following groups of human subjects are considered Vulnerable Populations:

- Children
- Wards of the State
- Prisoners
- Pregnant Women and Fetuses
- Persons Who Are Mentally Disabled or Otherwise Cognitively Impaired

Other Potentially Vulnerable Populations:

- Minorities
- Economically or Educationally Disadvantaged Subjects
- Illiterate English Speaking Subjects
- Employees as Subjects
- Students as Subjects
- Non-English-Speaking Subjects
- Terminally Ill Subjects

In reviewing research projects involving all categories of vulnerable subjects, the IRB must ascertain that their use is adequately justified and that additional safeguards are implemented to minimize risks unique to each group. A summary of the additional requirements for review and approval of research involving children, prisoners, and pregnant women and fetuses is presented below.

Research Involving Children

To safeguard their interests and to protect them from harm, special ethical and regulatory considerations apply for reviewing research involving children. The IRB may approve research involving children only if special provisions are met in addition to the other criteria required for approval. The IRB must classify research involving children into one of four categories and document their discussions of the risks and benefits of the research study. For more information, see IRB Policy 17.1 (Children in Research).

Federal regulations (Title 45 CFR 46, Subpart D) require that Investigators explicitly address the measures taken to protect the rights and welfare of children participating in protocols.

Definition of Children

"Children" are defined as "persons who have not attained the legal age for consent to treatments or procedures involved in the research, under the applicable law of the jurisdiction in which the research will be conducted." 45 CFR 46.402(a).
In Arkansas, children includes all those who have not yet reached their 18th birthday and have not been legally emancipated. Emancipation may be obtained through judicial decree or based upon certain events such as marriage or military service. Marriage or military service does not automatically emancipate an individual and Investigator’s should seek guidance per Policy 1.6 if the issue arises.

Investigators submitting proposals to the NIH for human subject research must include children in the study unless there are scientific or ethical reasons not to include them. The proposals must specifically include a description of plans for including children. And, if children will be excluded, the application must present an acceptable justification for the exclusion. Investigators should review the NIH Policy and Guidelines before submitting their proposals.

National Institutes of Health (NIH) Policy and Guidelines on the Inclusion of Children as Participants in Research Involving Human Subjects (March 6, 1998)

Categories of Research Involving Children

45 CFR 46, Subpart D, classifies research involving children into one of four categories depending upon the risks and benefits of the proposed research, which can be approved as follows:

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Pediatric Risk Category I: Research Not Involving More Than Minimal Risk. When the IRB finds that no greater than minimal risk to children is present, the IRB may approve the proposed research only if the IRB finds that adequate provisions are made for soliciting the assent of the children and the permission of their parents or guardians, as set forth below.

Pediatric Risk Category II: Research Involving Greater than Minimal Risk but Presenting the Prospect of Direct Benefit to the Individual Subjects. If the IRB finds that more than minimal risk to children is present by an intervention or procedure but that the intervention or procedure holds out the prospect of direct benefit for the individual subject, or by a monitoring procedure that is likely to contribute to the subject's well-being, the IRB may approve the research only if the IRB finds that:

1. The risk is justified by the anticipated benefit to the subjects;
2. The relation of the anticipated benefit to the risk is at least as favorable to the subjects as that presented by available alternative approaches; and
3. Adequate provisions are made for soliciting the assent of the children and permission of their parents or guardians, as set forth below

Pediatric Risk Category III: Research Involving Greater than Minimal Risk and No Prospect of Direct Benefit to Individual Subjects, but Likely to Yield Generalizable Knowledge about the Subject's Disorder or Condition. If the IRB finds that more than minimal risk to children is presented by an intervention or procedure that does not hold out the prospect of direct benefit for the individual subject, or by a monitoring procedure which is not likely to contribute to the well being of the subject, the IRB may approve the research only if the IRB finds that:

1. The risk represents a minor increase over minimal risk;
2. The intervention or procedure presents experiences to subjects that are reasonably commensurate with those inherent in their actual or expected medical, dental, psychological, social, or educational situations;
3. The intervention or procedure is likely to yield generalizable knowledge about the subjects' disorder or condition which is of vital importance for the understanding or amelioration of the subjects' disorder or condition; and
4. Adequate provisions are made for soliciting assent of the children and permission of their parents or guardians, as set forth below.

Pediatric Risk Category IV: Research Not Otherwise Approvable Which Presents an Opportunity to Understand, Prevent, or Alleviate a Serious Problem Affecting the Health or Welfare of Children. If the IRB does not believe the research proposal meets any of the requirements set forth above, it may still approve the protocol but only if:

1. The IRB finds that the research presents a reasonable opportunity to further the understanding, prevention, or alleviation of a serious problem affecting the health or welfare of children; and
2. The Secretary of the Department of Health and Human Services or The Commissioner of Food and Drugs, as applicable, after consultation with a panel of experts in pertinent
disciplines (for example: science, medicine, education, ethics, law) and following opportunity for public review and comment, has determined either that the research in fact meets one of the categories set forth above, or all of the following:

a. The research presents a reasonable opportunity to further the understanding, prevention, or alleviation of a serious problem affecting the health or welfare of children;

b. The research will be conducted in accordance with sound ethical principles; and

c. Adequate provisions are made for soliciting the assent of children and the permission of their parents or guardians, as set forth below.

Investigators should:

1.1 Design research projects involving children in accordance with this policy, making provisions to obtain the assent of all children over the age of 7. If the study population is such that the children will not be able to provide assent at the age of 7 or at all, the Investigator should specify this in the assent provisions of the application.

1.2 Identify in ARIA the pediatric category of research that the Investigator feels the project best meets and upload permission and/or assent documents.

Assent of Children

“Assent “ means a child’s affirmative agreement to participate in research. A child who fails to object to participation is not necessarily assenting to participation. Assent is not passive. “Permission” is the agreement of parent(s) or guardian to the participation of their child or ward in research.

The IRB must determine for all studies involving children

- The age of subjects where assent is required
- How and at what age assent is to be documented

Assent must be accompanied by the signed informed consent of the parent (parents) or legal guardian of the child. The Investigator must also inform the child of the purpose and the voluntary nature of their participation. This must be modified to the child’s age and ability to comprehend. The following are guidelines for age ranges in obtaining assent from children. These guidelines are recommended and are not intended to replace any institutional policies and procedures regarding the assent of children.

- Children younger than 7 years of age:
  If appropriate as determined by the child’s age and cognitive development, the Investigator should administer a simple oral explanation of the study procedures to be conducted.

- Children 7 years of age and less than 18 years of age:
  Written assent must be obtained from the child if it is an IRB requirement. Assent of a child should be obtained in the presence of a parent/legal guardian and witness.
The IRB encourages the Principal Investigator to submit classification information related to
the study’s risk category, age required for assent and method of assent documentation in the
initial study submission packet.

The IRB’s purpose is not to demand adherence to rigid criteria based solely on age, but to
use the age ranges above as guidelines for approaching children after taking into account
their emotional and cognitive development. For all children, but especially those with
developmental disorders, the age ranges listed above refer to the cognitive rather than the
chronological age.

The IRB reserves the right to require both parents’ permission on selected protocols if the
committee waives child assent or if additional requirements from the PI are deemed
necessary by the convened IRB. The IRB may consider a request from that PI that the
permission of one parent is sufficient for research involving greater than minimal risk, if
there is a clear prospect of direct benefit to the child-participant.

The requirements of parental permission may be waived in those cases where it is clear that
the parents’ interests do not adequately reflect the child’s interests (e.g., research on child
abuse or neglect). These research protocols require Investigators to develop special
procedures, which must be approved by the convened IRB that protects the rights and
welfare of the children asked to participate.

**There are NO exemptions for Research Involving Children’s Participation in Surveys
or Interviews**

Unlike research involving adults, the exemption at 45 CFR 46.101(b)(2) for research
involving survey procedures, interviews, educational tests, or public observations (except
where the Investigator does not participate in the activities being observed) does not apply
to research involving children. 45 CFR 46.401(b).

**Child Abuse Reporting**

The State of Arkansas requires the reporting of suspected child abuse or neglect.
Investigators must abide by this law. If the protocol involves interviewing children about
topics that might lead to a suspicion or to knowledge on the part of the Investigator of child
abuse or neglect, the child (and parent or guardian) must be informed of the reporting
requirement as part of the informed consent process.

The following sentence(s) should be integrated into the currently required Informed Consent
Document among the statements about confidentiality and its limits:

“We will attempt to maintain the confidentiality of any information you/your child give us in
the course of this study. However, you should be aware of limits to the confidentiality of
your information.”

“The researcher may also be required to report any child abuse or any intention you have to
hurt yourself or others. The researcher, if ordered to do so by a court of law, may be
required to disclose information you have provided.”
Wards of the State

Children who are wards of the state or any other agency, institution, or entity can be included in IRB research only if the IRB finds and documents that such research is: (1) related to their status as wards; or (2) conducted in schools, camps, hospitals, institutions, or similar settings in which the majority of children involved as subjects are not wards.

If the research is approved, the IRB must require appointment of an advocate for each child who is a ward, in addition to any other individual acting on behalf of the child as guardian. One individual may serve as advocate for more than one child. The advocate shall be an individual who has the background and experience to act in, and agrees to act in, the best interests of the child for the duration of the child's participation in the research and who is not associated in any way (except in the role as advocate or member of the IRB) with the research, the Investigator(s), or the guardian organization.

A foster parent may NOT give permission for a ward of the state to participate in research. Such permissions must be obtained through the Arkansas Department of Human Services.

Emancipated Minors

There are exceptions to the rule of obtaining assent and seeking parental permission for individuals considered emancipated minors by the state of Arkansas. "Emancipated minors" may include individuals under the age of 18, living on their own and financially independent from their parent or legal guardian, have borne a child, or are married. Consent is sought from an emancipated minor; not assent.

Research Involving Prisoners

Prisoners in Research

The special vulnerability of prisoners makes consideration of involving them as research subjects particularly important. Prisoners may be under constraints because of their incarceration, which could affect their ability to make a truly voluntary and uncoerced decision whether or not to participate as subjects in research. To safeguard their interests and to protect them from harm, special ethical and regulatory considerations apply for reviewing research involving prisoners.

Therefore, if a protocol involves the use of prisoners as subjects, or a subject becomes incarcerated after enrollment, both the general IRB Policies apply and the special ones outlined in this Policy apply. The IRB may approve research involving prisoners only if these special provisions are met.

Expedited Review of Research Involving Prisoners Not Allowed. The full IRB Committee must review research involving prisoners as human subjects.

Exemption from Review of Research Involving Prisoners Not Allowed. Research that would otherwise be exempt from the requirement that it receive IRB approval is not exempt when the research involves prisoners.
**Applicability of Policy Providing Special Protections for Prisoners.** This policy applies to anyone using the UAMS IRB as the IRB of record and any personnel subject to UAMS oversight in research involving prisoners.

Research involving prisoners does not qualify for exemption from IRB review. For more information, see IRB Policy 17.9, Prisoners in Research.

- **Categories Of Research Involving Prisoners [45 CFR 46.306(a)]**

  - Studies regarding the possible causes, effects, and processes of incarceration, and of criminal behavior, provided that the study presents no more than minimal risk and no more than inconvenience to the subjects.
  
  - Studies of prisons as institutions, or of prisoners as incarcerated persons, if those studies present no more than minimal risk or inconvenience to the subjects.
  
  - Research on conditions affecting prisoners as a class after HHS publishes a notice in the federal register.
  
  - Research on practices that are intended, and reasonably likely, to enhance the well-being of the subjects; however, if some of the prisoners will be assigned to control groups which will not benefit from the research, then the study must first be approved by HHS.

In addition to the general requirements for review, in reviewing prisoner research, IRBs are required by 45 CFR 46.305(a) to ensure that:

  - The membership of the IRB reviewing the protocol includes a prisoner or a prisoner representative with appropriate background and experience to serve in that capacity, and that the majority of the IRB is not associated with the penal institution involved. If no current member of the IRB meets the prisoner or prisoners’ representative criteria, then the IRB Chair will identify and recruit a qualified individual to fulfill this requirement and advise the IRB. In addition, a majority of the IRB members at the meeting must not be associated with the prison.
  
  - Any advantages that prisoners will realize as a result of participating in the research, when compared to the general living conditions within the prison, are not so great as to impair prisoner’s ability to weigh the risks and benefits of participation and freely choose whether to participate.
  
  - The risks involved in the research are commensurate with risks that would be accepted by non-prisoner volunteers.
  
  - Procedures for selecting subjects to determine are fair, and free from arbitrary manipulation by prison authorities or prisoners.
  
  - Control subjects will be selected randomly from among the group of eligible volunteers, unless the PI justifies a different procedure.
  
  - The information presented during the recruitment and consent procedures to ensure that it is in a language, and level of complexity, that is understandable to the subject population.
- The parole board will not take participation in the study into account, and that each prisoner will be informed that participation will have no effect on parole.

- Adequate provision will be made for follow-up care as necessary.

In addition, the FDA imposes specific restrictions on the use of prisoners in research involving FDA-regulated products. Use of prisoners in these studies is prohibited unless the specific requirements of this section are met (21 CFR 50, Subpart C). When an IRB reviews research falling within this category, its assurance provides for OHRP to be notified that the above criteria have been met.

### Prisoner Research Update

On June 20, 2003, the following information concerning research involving prisoners was published in the Federal Register:

Certain parts of 45 CFR 46 Subpart C were waived by DHS to allow DHHS to conduct or support certain important and necessary epidemiologic research on prisoners that presents no more than minimal risk and no more than inconvenience to the prisoner subjects. The Secretary of DHHS specifically proposed waiving the applicability of 45 CFR 46.305(a)(1) and 46.306(a)(2) for certain research conducted or supported by DHHS that involves epidemiologic studies that meet the following criteria:

1. In which the sole purposes are
   - To describe the prevalence or incidence of a disease by identifying all cases, or
   - To study potential risk factor associations for a disease, and
2. Where the institution responsible for the conduct of the research certifies to the Office for Human Research Protections, DHHS, acting on behalf the Secretary, that the IRB approved the research and fulfilled its duties under 45 CFR 46.305(a)(2)–(7) and determined and documented that
   - The research presents no more than minimal risk and no more than inconvenience to the prisoner-subjects, and
   - Prisoners are not a particular focus of the research.

The specific type of epidemiological research conducted or supported by DHHS and subject to the waiver involves no more than minimal risk and no more than inconvenience to the human subject participants. The proposed waiver would allow DHHS to conduct or support a type of minimal risk research that does not now fall within the categories set out in 45 CFR 46.306(a)(2).”

The range of studies to which the proposed waiver applies includes epidemiological research related to chronic diseases, injuries, and environmental health. This type of research uses epidemiologic methods (such as interviews and collection of biologic specimens) that generally entail no more than minimal risk to the subjects.

### Minimal Risk Definition For Prisoner Research and Non-Prisoners

The federal regulations list a different definition of minimal risk for prisoners in research from non-prisoners in research. The following information is from the OHRP Guidance on the Involvement of Prisoners in Research dated May 23, 2003:
Do not enroll a prisoner in an ongoing, IRB approved study without the approval of the committee. If a study subject becomes a prisoner during the course of the research, notify the IRB immediately.

**Research Involving Pregnant Women And Fetuses**

45 CFR 46 Subpart B, provides additional protections for research involving pregnant women. Pregnant women should not be excluded from research as participants if the risk to the fetus is minimal. If pregnant women are included in a research protocol, the informed consent must address the research activity and its possible impact on the fetus.

Researchers should obtain informed consent from both the pregnant woman and the father of the fetus. Consent by the father is not necessary if:

- The purpose of the study is to meet the health needs of the mother.
- The identity or whereabouts of the father can not be reasonably ascertained.
- The father is not reasonably available.
- The pregnancy is the result of rape.

Research targeting pregnant women as subjects cannot qualify for an exemption.

**Research Involving Cognitively Impaired Individuals**

The participation of cognitively impaired individuals in research typically falls in categories that cannot be reviewed using exempt procedures. In addition, projects involving cognitively impaired individuals must specifically address how an individual’s capacity to give informed consent will be determined. *Examples of cognitive impairment include: diagnosed mental retardation, dementia, and coma.*

The IRB is not in a position to determine if an individual identified with a cognitive impairment has the capacity to give informed consent.

CAVHS permits the use of a surrogate consent process for persons who are cognitively impaired. The IRB advises the use of the decision algorithm when it is unclear if cognitive impairment may prevent a subject from giving informed consent.

For more information, see [IRB Policy 17.2 (Cognitively Impaired Persons)](#).
**Legally Authorized Representatives (LARS)**

In Arkansas, in addition to other persons as may be authorized and empowered, the legally authorized representative for another person, for purposes of providing consent for research involving surgical or medical treatments or procedures, not prohibited by law, which might be suggested, recommended prescribed or directed by a licensed physician, is any one the following:

1. Any parent, whether an adult or a minor, for his minor child or adult child of unsound mind. Child as used here includes biological, adopted, step or foster children. The father of an illegitimate child, however, cannot consent for the child solely on the basis of parenthood;
2. Any person standing in loco parentis, whether formally serving or not;
3. Any guardian, conservator, or custodian, for his ward or other charge under disability;
4. Any adult for a minor sibling or adult sibling of unsound mind;
5. If an authorized parent is absent, any maternal grandparent and, if the father is an authorized parent, any paternal grandparent, for a minor grandchild or for an adult grandchild of unsound mind;
6. Any married person, for a spouse of unsound mind; or
7. Any adult child, for their mother or father of unsound mind.

For more information, see IRB Policy 17.13 (Legally Authorized Representatives). Note VA has different rules, see IRB Policy 17.2.

**Other Potentially Vulnerable Populations**

- **Economically or Educationally Disadvantaged Subjects**

  For research involving economically disadvantaged subjects, special care must be taken to assure that the financial inducements offered do not constitute the sole grounds for the subject participation in the research protocol. Financial inducements should also not be used to assume risks that subjects would not ordinarily incur.

  The consent form for research involving educationally disadvantaged subjects should be written with special attention to assure that terminology has been sufficiently simplified. The Investigator should discuss orally every aspect of the study with the subjects to insure their understanding.

- **Illiterate English Speaking Subjects**

  An Investigator in an IRB approved study may enroll individuals who can speak and understand English, but cannot read or write. The potential subject must be able to place a written mark on the consent form.

  The subject must also be able to:

  - Comprehend the concepts of the study and understand the risks and benefits of the study as it is explained verbally, and
  - Be able to indicate approval or disapproval for study enrollment.
If an Investigator uses the above method to obtain consent, there must be documentation on the subject’s consent form specifying what method was used to communicate the information and the specific means that the subject communicated agreement to study participation.

### Employees as Subjects

Employees may be recruited as study subjects. However, Investigators should avoid using their own employees as research participants because of potential coercion and undue influence. The preferred method of recruiting employees for research studies is notices on institutional bulletin boards or third party notification, e.g. word of mouth. No directed advertising among one’s own employees should be used. Recruitment notices, including bulletin board or newspaper ads, are to be submitted to the IRB before they are posted or submitted for publication.

### Students as Subjects

Recruiting students as subjects represents a potential problem for Investigators. Possible coercion is an issue from a student participating in a study conducted by his or her advisor. Undue influence is an issue whenever a student’s participation will be made known to someone who holds power over his or her academic status. How the Investigator plans to handle potential problems of coercion and undue influence must be addressed in the initial submission of the study to the IRB. In particular, activities that involve students who report directly to the Investigator or attend a class for which the Investigator has responsibility must be described.

### Non-English-Speaking Subjects

Non-English-Speaking subjects may not be excluded from therapeutic studies on the basis of language use if there is a possibility that they might benefit by participating in the study.

If a research subject does not understand English, the informed consent document should be in the language readily understood by the subject to meet the requirements of 21 CFR 50.20. If the principal Investigator anticipates that consent interviews will be routinely conducted in a language other than English, the IRB requires a translated consent document be submitted with the original protocol for approval. It is the Investigator’s responsibility to ensure that the translation is accurate.

As required by 21 CFR 50.27, a copy of the consent document must be given to each subject. While a translator may be helpful in facilitating conversation with a Non-English-Speaking subject, verbal translation of the consent document must not be substituted for a written translation.

If a Non-English-Speaking subject is unexpectedly encountered, see IRB Policy 15.4, Non-English-Speaking Research Subjects.
Terminally Ill Subjects

From the Office of Human Research Protections (OHRP) IRB Guidebook:

Terminally ill patients are those who are deteriorating from a life-threatening disease or condition for which no effective standard treatment exists. It is generally considered unacceptable to ask such persons to participate in research for which alternative, not similarly burdened, populations of subjects exist. Nevertheless, it may often be necessary to involve terminally ill patients in research concerning their disease and its treatment. Further, terminally ill persons should not be excluded from research in which they may want to participate simply because of their status. One can imagine that altruism and a desire to bring good from adversity may well motivate persons suffering from life-threatening illnesses to become involved in biomedical or behavioral research. Still, terminally ill individuals are a vulnerable population of research subjects, and, therefore, require additional protection against coercion and undue influence.

[45 CFR 46.111(b)]

The risk of coercion and undue influence may be caused by a variety of factors. In addition to the fact that severe illness often affects a person's competence, terminally ill patients may be vulnerable to coercion or undue influence because of a real or perceived belief that participation is necessary to receive continuing care from health professionals or because the receipt of any treatment is perceived as preferable to receiving no treatment. Although terminally ill patients should be protected from an understandable tendency to enroll in research under false hopes, IRBs should not take too protective an attitude toward competent patients simply because they are terminally ill. Some terminally ill patients may find participation in research a satisfying way of imparting some good to others out of their own misfortune.

It is important to distinguish between risks that may be justified by anticipated benefits for the research subjects and risks associated with procedures performed purely for research purposes. A particularly difficult issue relating to research involving terminally ill patients arises in connection with the conduct of Phase 1 drug trials in which the drugs involved are known to be particularly toxic (e.g., a new form of cancer chemotherapy). In some of these studies, any benefit to the subject is, at best, highly unlikely. Despite the "therapeutic intent" of the Investigators to benefit the subject, subjects may in fact experience a decline in health status, no improvements in terms of quality of life, or lengthened life for only a short time. It is extremely important that prospective subjects be clearly informed of the nature and likelihood of the risks and benefits associated with this kind of research. The challenge to the Investigator and the IRB is to provide patients with an accurate description of the potential benefits without engendering false hope.
Research in Nursing Homes

Aside from the regulatory requirement that IRBs provide additional protections for specially vulnerable persons, there are no specific regulations governing research with elderly subjects. The elderly are, as a group, heterogeneous and not usually in need of special protections, except in two circumstances: cognitive impairment and institutionalization. Under those conditions, the same considerations are applicable as with any other, non-elderly subject in the same circumstances. See IRB policy 17.2 for discussion of cognitive impairment.

Institutionalization: In the past, persons in nursing homes or other institutions have been selected as subjects because of their easy accessibility. However, conditions in institutional settings increase the chances for coercion and undue influence because of the lack of freedom inherent in such situations. Research in these settings should therefore be avoided, unless the involvement of the institutional population is necessary to the conduct of the research (e.g., the disease or condition is endemic to the institutional setting, persons who suffer from the disease or condition reside primarily in institutions, or the study focuses on the institutional setting itself).

IRB Considerations: When a research study is undertaken at a nursing home, all necessary parties are informed and all documentation is maintained in a manner that meets all local, state, and federal research requirements.

For more information, see IRB Policy 17.4 (Subjects in Long Term Care).
CHAPTER 13

Payment/Reimbursement of Research Subjects

This section concerns the payment and reimbursement of research subjects.

Subject Compensation
Recruitment of Study Subjects
Billing Of The Research Subject at UAMS
Billing For Research Activities
Subject Compensation

Compensation or payment to research subjects for participation in studies is not considered a benefit. Rather, it should be considered compensation for time and inconvenience. The amount and schedule of all payments should be presented to the IRB at the time of initial review.

1. **Timing of Payments.** Credit for payment should accrue as the study progresses and not be contingent upon the subject completing the entire study. The subject should be paid in proportion to their time and inconvenience as a result of participation in the research study. Unless it creates undue inconvenience or a coercive practice, payment to subjects who withdraw from the study may be paid at the time they would have completed the study (or completed a phase of the study) had they not withdrawn. For example, in a study lasting only a few days, an IRB may find it permissible to allow a single payment date at the end of the study, even to subjects who had withdrawn before that date.

2. **Completion Bonus.** While the entire payment should not be contingent upon completion of the entire study, payment of a small proportion as an incentive for completion of the study is acceptable, providing that such incentive is not coercive. The IRB will determine whether the amount paid as a bonus for completion is reasonable and not so large as to unduly induce subjects to stay in the study when they would otherwise have withdrawn.

3. **Disclosure of Payments.** All information concerning payment, including the amount and schedule of payment(s) should be set forth in the informed consent document.

4. **Advertisement of Payments.** Advertisements may state that subjects will be paid or compensated, but should not emphasize the payment or the amount to be paid, by such means as larger or bold type.

**Alterations in Payments.** Any alterations in human research subject payment or liberalization of the payment schedule must be reported to the IRB prior to implementation as an amendment.

**VA Research Participants:** VA policy prohibits paying human subjects to participate in research when the research is integrated with a patient’s medical care and when it makes no special demands on the patient beyond those of usual medical care. Payment may be permitted, with IRB approval, in the following circumstances:

1. **No Direct Subject Benefit.** When the study to be performed is not directly intended to enhance the diagnosis or treatment of the medical condition for which the volunteer subject is being treated, and when the standard of practice in affiliated non-VA institutions is to pay subjects in this situation.

2. **Others Being Paid.** In multi-institutional studies, when human subjects at a collaborating non-VA institution are to be paid for the same participation in the same study at the same rate proposed.
(3) **Comparable Situations.** In other comparable situations in which, in the opinion of the IRB, payment of subjects is appropriate.

(4) **Transportation Expenses.** When transportation expenses are incurred by the subject that would not be incurred in the normal course of receiving treatment and which are not reimbursed by any other mechanism.

**VA Investigators** who wish to pay research subjects must in their proposal:

1. Substantiate that proposed payments are reasonable and commensurate with the expected contributions of the subject;
2. State the terms of the subject participation agreement and the amount of payment in the informed consent form; and
3. Substantiate that subject payments are fair and appropriate, and that they do not constitute (or appear to constitute) undue pressure or influence on the perspective research subjects to volunteer for, or to continue to participate in, the research study; and that the payments do not constitute (or appear to constitute) coercion to participate in, or continue to participate in, the research study.

The IRB will review both the amount of payment and the proposed method and timing of disbursement to assure that neither are coercive nor present undue influence.

Each institution (ex. UAMS, CAVHS and ACH/ACHRI) has its own policies regarding the appropriate handling of payments to research subjects. The PI is responsible for following the appropriate policies.

**Recruitment of Study Subjects**

The UAMS IRB is responsible for ensuring the equitable selection of research participants with the proper safeguards in place to protect the rights and welfare of the participants. In fulfilling this responsibility, the UAMS IRB will review the methods and materials that investigators use to recruit subjects.

No matter the method chosen to identify potential research participants, provisions must be in place to protect the individual's right to privacy.

Contacting primary care providers (PCP) for access to potential participants from the patient population of the PCP is another method of potential recruitment. This would require IRB approval prior to initiation and the PCP may be subject to HIPAA restraints that would prevent him/her from sharing PHI with the Investigator.

Searching Medical Records or other Databases of Patient information looking for potential participants requires IRB approval prior to the search. (NOTE: A search to find out if a patient population exists in anticipation of a research project would not be considered recruitment provided no identifying information was retained to be used later.)
1. Advertising for research subjects. When advertising is to be used, the UAMS IRB will review the information contained in the advertisement, and the mode of its communication, to determine that the procedure for recruiting subjects affords adequate protection. Advertisements used to recruit subjects should be seen as an extension of the informed consent and subject selection processes. Therefore, the UAMS IRB will review all advertisements to ensure that the information is not misleading to subjects, especially when a study will involve persons with acute or severe physical or mental illness or persons who are economically or educationally disadvantaged.

Generally, any advertisement; print, electronic or other media, to recruit subjects should be limited to:

1. The name and address of the clinical investigator and/or the research facility
2. The purpose of the research and that it is in fact research
3. The eligibility criteria that will be used to admit subjects to the study
4. A straightforward and truthful description of the benefits or burdens (e.g., reimbursements, no cost treatment, placebo control) to the subject for participating in the study
5. The time or other commitment required from the subject
6. The location of the research and the person to contact for further information

Advertisements, regardless of form, may not:
1. Be Misleading or Coercive either in wording or visual effects
2. Promise a Favorable Outcome
3. Promise “Free Medical Treatment” if the intent is simply that there is no charge to partake in the research project.
4. Imply any benefits beyond what is outlined in the consent and protocol
5. Use terms such as “New Treatment”, “New Drug”, “New Medication” without explaining that the test article is investigational
6. Emphasize amount of payment for participation
7. Make claims, either explicitly or implicitly, that a drug or device is safe or effective for the purposes under investigation, or that the drug or device is in any way equivalent or superior to any other drug or device.

❖ Billing Of The Research Subject at UAMS

Principal Investigators are required to follow the policies and procedures of the institution when billing research and clinical costs. At UAMS, the PI is to follow the policy “Billing for Research Procedures”. All efforts should be made to assure that research subjects are billed in a correct and ethical manner. Consent forms should clearly differentiate what costs the subject will be responsible for and what costs the study will pay.

❖ Billing For Research Activities

Prior to submission of the protocol, make plans to establish correct billing procedures for research.
PURPOSE

The purpose of this section is to define the procedure of processing payment requests for research subjects that are not employees of the University of Arkansas for Medical Sciences. Payments to employees are processed through Human Resources and procedures are detailed on a separate Policy Statement.

PROCEDURE

1. For payments to non-employees that are individually less than $200 each, a Petty Cash Voucher is submitted to the Treasurer’s Office. This form lists names, addresses, amounts and fund/account/cost center numbers that will be charged in the General Ledger accounting system. The form must have the approval signature of an authorized departmental disbursing officer. Checks will be prepared and either released to departmental representatives or mailed directly to the research subjects. Payments to research subjects participating in projects requiring anonymity will also be processed through Petty Cash, with checks payable to an authorized departmental representative.

2. For IRS reporting purposes, payment requests for non-employees in amounts equal to or greater than $200 must be processed on a Purchase Requisition and sent to the Procurement Department. The social security number for each subject will be required information on the Purchase Requisition. For individuals receiving $600 or more during a calendar year, an IRS 1099 form will be sent to the individual subjects and reported to the IRS as taxable income.

3. If anticipated total payments to an individual research subject exceed $600, the department should process the payment request through Procurement on a Purchase Request, even if individual payments may be less than the $200 limit. This will allow the capture of information for 1099 reporting to the IRS.

For more information on payments to research subjects, see Policy 8.7.01 in the UAMS Administrative Guide.
CHAPTER 14

Educational Policies And Resources

This section concerns educational policies and resources.

Investigators And Study Staff

Training Links For Researchers Using UAMS IRB
Additional Training Links For Researchers At CAVHS
Training Policy
- **Investigators And Study Staff**

IRB policy is that all Investigators desiring to engage in research using human subjects must familiarize themselves with IRB policies and procedures and related federal regulations. Investigators should maintain an on-going relationship with the IRB to gain assistance in following policies and procedures during the conduct of their studies. This will help assure that both Investigators and the IRB remain in compliance with all state and federal regulations regarding research involving human subjects.

- **Training Links For Researchers Using UAMS IRB**

  Human Subject Protection Training – [www.uams.edu/ORC](http://www.uams.edu/ORC)
  
  HIPAA for Research Training – [www.uams.edu/ORC](http://www.uams.edu/ORC)

- **Additional Training Links For Researchers At CAVHS**

  
  VHA Privacy Policy - [http://www1.va.gov/resdev/fr/PRIDE/training/](http://www1.va.gov/resdev/fr/PRIDE/training/)

- **Training Policy**

For more information regarding UAMS education policy, see [Policy Number 12.1.06 in the UAMS Administrative Guide](http://www1.va.gov/resdev/fr/PRIDE/training/).
CHAPTER 15

IRB Authority In Non-Compliance Issues

When the IRB is notified of events for which review is necessary by the convened IRB, the IRB chair or designated Chair will bring the issue to the attention of the IRB for appropriate action.

If the IRB is notified of events that indicate potential regulatory noncompliance, the committee will attempt to provide assistance through written contingencies to assist the Investigator with achieving compliance without the imposition of sanctions. However, in cases where Investigator cooperation does not occur and/or when it is determined that the safety or welfare of subjects or the integrity of the institution are or have been placed at risk, sanctions may be imposed.

Non-Compliance Issues

Study Closure

Reopening Of A Closed Study

Suspension

Termination

Appeals Procedures For IRB Actions
Non-Compliance Issues

The IRB has the regulatory authority to:

- Increase the frequency of continuing review
- Appoint a subcommittee of appropriately qualified IRB members to investigate alleged non-compliance issues and advise the convened IRB
- Suspend study approval until compliance is achieved
- Terminate individual research protocols
- Report specific non-compliance activities of the Investigator to appropriate governmental entities
- To request the UAMS Office of Compliance to perform a targeted review of study records and data

The IRB also has the regulatory authority to recommend additional sanctions to the Vice Chancellor for Academic Affairs and Research (VCAA/RA). These sanctions include:

- Research privilege probation
- Suspension of research privileges
- Termination of research privileges
- Embargo of publications.

The Principal Investigator will be notified in writing if the IRB is investigating non-compliance issues and may be requested to cease all accrual or all interaction with subjects. Following the investigation and subsequent deliberations of the IRB, the Investigator will be provided written findings with one of the following actions:

- The research may continue
- The research may continue after contingencies are satisfactorily addressed
- The research may not continue due to placement or recommendation of sanctions

The IRB is required to report to the Vice-Chancellor for Academic Affairs and Sponsored Research, institutional officials, sponsoring agencies, the US Office for Human Research Protections (OHRP) and grants management officers concerning any suspension or termination of research protocols. If the protocol involves drugs or devices, the IRB is also required to notify the Food and Drug Administration (FDA).

If the protocol involves the Veterans Administration, the IRB will also notify the VA R & D Committee and the Office for Research Oversight (ORO).

The IRB is also required to report to these agencies any unanticipated problems involving risks to subjects or others, and serious or continuing non-compliance as determined by the IRB [45 CFR Part 46.103(b) (5)].
The UAMS IRB, UAMS Office of Research Compliance and the UAMS Vice Chancellor for Academic Affairs (VCAA/RA) work cooperatively to assure compliance of all studies under the IRB’s review. Institutions other than UAMS who use the UAMS IRB also have assurance requirements for compliance.

All reports of alleged non-compliance or inappropriate involvement of humans in research will be investigated. Such reports may be received from any source by the UAMS IRB Staff, chair or members, the ORC, or the VCAA/RA. For more information on the process, see IRB Policy 12.4 (Non-compliance with Human Research Protection Program Requirements).

❖ Study Closure

Study closure is a voluntary process and carries no punitive implications. Closure is not reported to institutional officials or to the department or agency head. Closure typically applies in the following situations:

- At the completion of the study (i.e., new enrollment is closed and all data collection and analysis are completed);
- If the Investigator chooses to close the study (e.g., the study has not met its enrollment goal, but the Investigator does not plan to enroll new subjects, collect additional data from enrolled subjects, or perform any additional data analysis);
- The Investigator leaves the institution and does not intend to transfer responsibility for the study to another Investigator.

The Investigator must request study closure. The IRB office must be notified when a study is completed. This notification should be sent when all participants have completed treatment and follow-up phases of the study and analysis is completed to the point that the participant’s records will no longer be needed. The Investigator must complete the Study Closure Form through ARIA that addresses the following:

- Protocol title and record number
- Name of PI
- Number of subjects accrued
- Number of subjects completing study
- Any publications that have resulted from data collected during the study
- Any adverse events that have not been previously reported.

The final report of study results should be received by the IRB within 30 days of decision to close a study. Investigators may request closure of a study upon continuing review or by submitting a separate study closure form.

If no subjects have been enrolled in the previous five years and all data collection is complete, the Investigator should close the study. Studies that are not closed properly by the PI may be terminated.
Re-opening Of A Closed Study

An Investigator may request that a closed study be re-opened within six months of that closure with a written request to the IRB and any updated information. After six months of closure or if updated information is significant, a new submission may be required.

Suspension

Suspension is a non-permanent interruption of research activities. Suspension may occur for the following reasons:

- Unexpected and serious adverse effects that significantly increase risks relative to benefits
- Evidence that an Investigator failed to adequately protect participants in a research study
- Willful or repeated failure to comply with federal regulations, state laws, or institutional rules that govern human research activities
- Proven research fraud or scientific misconduct
- At the request of institutional officials who have been charged with responsibility for oversight of research involving human subjects (e.g., the Chancellor or the Vice Chancellor for Academic Affairs and Research Administration).
- At the request of the study sponsor, the FDA, the Office for Human Research Protections, or other duly authorized regulatory or governmental department or agency head
- Any other reason deemed necessary by a simple majority vote of a convened IRB Committee (a quorum must be present)
- The IRB or the Investigator decides that new enrollment and risk-bearing activities should be interrupted pending an investigation into any problem or alleged problem with a particular study
- Any study may be suspended by majority vote of the IRB members at a convened meeting with a quorum present. A study that is suspended may be reopened without resubmission as a new protocol and consent form. If discontinuation of study-related therapy might result in increased risk of significant harm to an individual or a group of study subjects, the IRB reserves the right to permit continued therapy with an investigational drug, device, or biologic for subjects who are already enrolled in a treatment study. Enrollment of new subjects generally will not be permitted. However, at the request of the Investigator, the IRB Chair or a designee may permit enrollment into a suspended study if and only if there is no alternative therapy for a life-threatening condition.

At the time the study is suspended, the IRB will establish a unique and specific plan that, if completed, by the PI, will lead to re-review of the study resulting in a decision as to whether to continue or end the suspension or to terminate the study. An audit of the Investigator’s studies may be undertaken. As a minimum, the unique and specific plan will include a set of questions or conditions that must be addressed completely by the Investigator and a specified time period during which the Investigator must provide a written response.
If an emergency occurs, institutional officials, the IRB Chair, or an appropriately appointed designee may suspend a study until the next regularly scheduled meeting of the IRB. Alternatively, the Chair may convene an emergency meeting of the full committee to consider suspension of a study before the next regularly scheduled meeting. In the event that an emergency suspension is considered, the Chair must notify the PI and appropriate institutional officials (e.g., the Chancellor, the Vice Chancellor for Academic Affairs and Research Administration, the Director of the ORSP, direct supervisors of the PI, and the appropriate department of agency head). The full committee at the next scheduled meeting must review all emergency suspensions.

**Termination**

Termination is a non-voluntary process that results in permanent discontinuation of all study-related activities. The IRB may require a study that has been terminated to be entirely resubmitted and re-approved with a new protocol. Termination may occur for the following reasons:

- Unexpected and serious adverse effects that significantly increase risks relative to benefits
- Evidence that an Investigator failed to adequately protect participants in a research study
- Willful or repeated failure to comply with federal regulations, state laws, or institutional rules that govern human research activities
- Proven research fraud or scientific misconduct
- At the request of institutional officials who have been charged with responsibility for oversight of research involving human subjects (e.g., the Chancellor or the Vice Chancellor for Academic Affairs and Research Administration)
- At the request of the study sponsor, the Federal Drug Administration, Office for Human Research Protections, or other duly authorized regulatory or governmental department or agency head
- The Investigator leaves the institution and fails to request closure of the study or fails to reassign the Investigator’s responsibilities and duties to another qualified Investigator
- Failure to respond to repeated requests from the IRB regarding required actions on the part of the Investigator to maintain an active protocol
- Any other reason deemed necessary by a simple majority vote of the convened IRB (a quorum must be present)

A research study that is terminated by the IRB will be reported to the study sponsor, institutional officials, and to the appropriate department or agency head. Disciplinary action or sanctions may be appropriate. Decisions will be made on a case-by-case basis. At the IRB level, appropriate sanctions might include a request for further information, an audit of ongoing clinical research activities, or suspension of all ongoing research conducted by the same Investigator or group of Investigators until all research activities are shown to be free of similar problems. The Investigator will be reminded that if a study is terminated, no further enrollment or data collection is permitted.

If discontinuation of study-related therapy might result in increased risk of significant harm to an individual or a group of study subjects, the IRB reserves the right to permit continued therapy with
an investigational drug, device, or biologic for subjects who are already enrolled in a treatment study. Enrollment of new subjects will not be permitted.

Institutional officials have the right to terminate any research activity without review by or approval of the IRB. Institutional review is broader in scope and may result in termination for reasons, other than those listed above.

❖ Appeals Procedures For IRB Actions

Information pending.
CHAPTER 16

IRB Records

This section concerns IRB records.


IRB Records

The IRB office maintains the following records:

- A current list of IRB membership and qualifications.
- Agenda and minutes of meetings, including information regarding member attendance, discussions held, decisions made, and voting results.
- All materials submitted to the committee for initial and continued review of each study including: IRB applications, protocols, submitted and final consent forms, serious adverse event and death reports, proposed amendments, progress reports, correspondence generated between the committee and the Investigators, and, where applicable, correspondence from sponsoring agencies.

All records are retained electronically following the inactivation or closure of a project.
CHAPTER 17

Office of Research Compliance

This section offers information about the Office of Research Compliance.

ORC Information
ORC Information

The Office of Research Compliance (ORC) was established to help researchers and the entire University achieve and maintain compliance with federal regulations and institutional requirements governing research. The ORC’s primary purpose is to support activities that protect human subjects and to elevate the general level of research through systematic evaluation of research activities. The ORC coordinates the implementation and oversight of a comprehensive research compliance program for the University. As part of its role, the ORC conducts audits, educates staff on research and regulatory compliance, and reviews potential noncompliance.

The ORC is a department of the Academic Affairs Division and reports directly to the UAMS Vice Chancellor for Academic Affairs and Research Administration. It also functions as the auditing and compliance body for the UAMS Institutional Review Board.

Study audits conducted by the ORC include random or selected audits, directed or “for cause” audits, and specific document or process audits. The IRB may ask the ORC to conduct an audit based on an Investigator’s protocol activities (large numbers of active protocols, subject enrollment, reported protocol deviations and/or serious adverse events). The ORC also may initiate audits as quality assurance or safety assessments or as educational activities for researchers. Audit findings are reported to the UAMS IRB, Investigator and the UAMS Vice Chancellor for Academic Affairs and Research Administration.

The ORC, upon the request of research staff, will conduct a review of documents in preparation for an external agency audit such as the FDA or NIH.

Education is a very large focus for the ORC. Education of researchers and their staff is accomplished through quarterly coordinator training classes, monthly one-hour Question and Answer seminars, and through advisory consultation sessions. Interactive web-based training programs are available in the areas of Protection of Human Subjects (Biomedical and Behavioral) and HIPAA for Research.

Regulatory consultations for the preparation of Sponsor-Investigator Investigational New Drug (IND) exemptions and Monitoring of IND studies and informational packets on the preparation are available for Investigators who want to conduct research under their own IND.

The ORC will review and advise on protocols and protocol preparation when requested. This office will also advise Investigators preparing their own dosage forms on current Good Manufacturing Practices (cGMP).

To contact the Office of Research Compliance:

Telephone: 501-526-6876
Facsimile: 501-526-6272
Website: http://www.uams.edu/orc/
CHAPTER 18

References

This section offers references that can be used in research.

Ethical Principals And Codes
Federal Regulatory & Advisory Guidelines
Federal Regulatory Agencies
Local References
Accreditation References
Ethical Principles And Codes

- Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research
- Guidelines for Good Clinical Practice
- International Conference on Harmonization of Technical Requirements for Registration of Pharmaceuticals for Human Use (ICH)
- ICH Considerations for Clinical Trials
- National Bioethics Advisory Commission
- Nuremberg Code
- World Medical Association Declaration of Helsinki

Federal Regulatory & Advisory Guidelines

- Code of Federal Regulations
- Department of Veterans Affairs M3-Part I
- FDA Information and Regulations
- Investigational Devices 21 CFR 812 – U.S. FDA
- Investigational Drugs 21 CFR 312 and 314 – U.S. FDA
- NIH Policy and Guidelines on the Inclusion of Children as Participants in Research Involving Human Subjects
- Protecting Human Research Subjects: Institutional Review Board Guidebook (NIH/OPRR)
- Protection of Human Subjects 21 CFR 50 – U.S. FDA
- Protection of Human Humans 38 CFR 16 – U.S. FDA
- Protection of Human Subjects 45 CFR 46 – U.S. FDA
- HIPAA Privacy and Research 45 CFR 164

Federal Regulatory Agencies

- National Institutes of Health
- Office of Biotechnology Activities
- Office for Research and Compliance
- Office of Human Research Protections
• U.S. Food and Drug Administration

❖ Local References

UAMS Faculty Handbook
UAMS Federalwide Assurance
UAMS IRB Investigators Handbook for Human Studies
UAMS IRB Policies and Procedures

❖ Accreditation References

CHAPTER 19

Glossary

This section contains glossary items.

Glossary Items
Glossary Items

- **Accrual**
  The process of getting subjects into a trial or the number of subjects in a trial or planned to be in a trial. The number of subjects includes the sum of those screened and enrolled (regardless of whether they completed the study).

- **Adult Risk**
  The probability of harm or injury (physical, psychological, social, or economic) occurring as a result of participation in a research study. Both the probability and magnitude of possible harm may vary from minimal to significant. Federal regulations define only "minimal risk."

- **Adult Minimal Risk**
  A risk is minimal where the probability and magnitude of harm or discomfort anticipated in the proposed research are not greater, in and of themselves, than those ordinarily encountered in daily life or during the performance of routine physical or psychological examinations or tests [38CFR16.102(i)].

- **Approved**
  The project and its study tools, including the informed consent documents, are approved as submitted. Once the investigator receives the IRB approval letter, the study may begin.

- **Approved with Major Revisions**
  A vote such as this incorporates all the noted contingencies. The project requires major revisions which must be addressed and re-reviewed by the convened IRB before the IRB can grant final approval.

- **Approved with Minor Revisions**
  A vote such as this incorporates all the noted contingencies. The project requires minor revisions which must be addressed before final approval can be granted. Minor revisions may be reviewed and approved through the expedited process.

- **Arm**
  Any of the treatment groups in a randomized trial.
• Assent

A child’s affirmative agreement to participate in research. Mere failure to object should not, absent affirmative agreement, be construed as assent. Assent is generally sought beginning at age 7. Assent is a process, not a form. However, Assent can be documented either on a separate assent form specifically tailored to children (especially adolescents) or on the same document used to obtain parental permission.

• Audit

A comparison of Raw Data and associated records with the interim or Final Study Report in order to determine whether the Raw Data have been accurately reported, to determine whether testing was carried out in accordance with the protocol and Standard Operating procedures (SOP), to obtain additional information not provided in the Final Study Report, and to establish whether practices were employed in the development of data that would impair their validity.

• Benefit

A valued or desired outcome; an advantage.

• Blind

Used with respect to a randomized trial, a randomized trial is blind if the subject is not told which arm of the trial he or she is on.

• Certificate of Confidentiality

Where data are being collected from subjects about sensitive issues (such as illegal behavior, alcohol or drug use, or sexual practices), researchers can obtain an advance grant of confidentiality from the Public Health Service that will provide protection against involuntary disclosure of the research subject’s identity and the subject’s participation in the study, even against a subpoena for research data.

• Children

Persons who have not attained the legal age for consent to treatment procedures involved in the research, as determined under the applicable law of the jurisdiction in which the research will be conducted [45 CFR 46.402 (a)].

• Clinical Investigation

Any experiment that involves a test article and one or more human subjects and that is subject to the Food and Drug Administration (FDA) regulations. This includes all research using a test article in a human subject as well as experiments that support applications for research or marketing permits for products.
• Clinical Trials
Any form of planned experiment, which involves subjects and is designed to elucidate the most appropriate treatment of future subjects with a given medical condition. The essential characteristic of a clinical trial is that the results based on a limited sample of subjects are used to make inferences about how treatment should be conducted in the general population of subjects who will require treatment in the future.

• Cognitively Impaired Individuals
Those persons having a psychiatric or developmental disorder that affects cognitive or emotional functions to the extent that the capacity for judgment and reason is significantly diminished.

• Compassionate Use
Use of an investigational drug for treatment of an individual subject for a single use or a single course of treatment that is not covered by an existing IRB approved protocol.

• Compliance
Action in accordance with a request or institution.

• Consumer Preference Testing
Studies in which preferences are measured for approved devices or modifications of approved devices. Such testing does NOT involve the collecting of safety or efficacy data.

• Continuing Non-compliance
A pattern of repeated actions or omissions taken by an Investigator (or study personnel) that indicates a deficiency in the ability or willingness to comply with Federal Regulations, UAMS and/or other institutional policies and procedures, or the determinations of the UAMS IRB.

• Current Good Manufacturing Practices (cGMP)
The minimum requirements for methods to be used in, and the facilities or controls to be used for, the manufacture, processing, packing, or holding of a drug or biologic to assure that such drug meets the requirements of the Food, Drug, and Cosmetic Act as to safety, and has the identity and strength and meets the quality and purity characteristics that it purports or is represented to possess.

• Current Good Tissue Practices (cGTP)
The minimum requirements for methods to be used in, and the facilities or controls to be used for, the manufacture of human cell, tissue, and cellular and tissue-based products (HCT/P); recordkeeping; and the establishment of a quality program. (Effective May 25, 2005)
• Data and Safety Monitor (DSM)
An individual assigned to conduct interim monitoring of accumulating data from research activities to assure the continuing safety of research participants, relevance of the study question, appropriateness of the study, and integrity of the accumulating data. The individual should have relevant medical, ethical and scientific, and monitoring expertise.

• Data and Safety Monitoring Board (DSMB)
A formally appointed independent group consisting of at least three (3) members assigned to conduct interim monitoring of accumulating data from research activities to assure the continuing safety of research participants, relevance of the study question, appropriateness of the study, and integrity of the accumulating data. Membership should include expertise in the relevant field of study, statistics, and research study design. DSMBs are often referred to as Data and Safety Monitoring Committees (DSMC).

• Data Safety Monitoring Plan (DSMP)
A DSMP describes how the Investigator plans to oversee the research participant’s safety and welfare and how adverse events will be characterized and reported. The intensity and frequency of monitoring should be tailored to fit the expected risk level, complexity, phase and size of the particular study.

• Dead Fetus
A fetus ex utero, which exhibits none of the following: heartbeat, spontaneous respiratory activity, spontaneous movement of voluntary muscles, nor pulsation of the umbilical cord (if still attached).

• Declined
The project has serious deficiencies affecting the safety and welfare of the projected subject population. Protocols that are declined may not be resubmitted to the IRB under the same ARIA Record. The protocol requires major revision of safety issues and an entirely new protocol submission. The PI will be provided with comments explaining rationale for Declined decision.

• Double Blind
Used with respect to a randomized trial, a randomized trial is Double Blind if neither the subject or the subject’s Investigator or physician are told which Arm of the study he or she is on. The purpose is to prevent any bias in treatment or reporting of results from being introduced.
• Economically Disadvantaged Individuals
Those persons who struggle to provide basic necessities for themselves and their families or communities. The use of financial incentives for research participation is a special issue with economically disadvantaged persons.

• Educationally Disadvantaged Individuals
Those persons who may have educational deficits, learning disabilities, or cultural backgrounds that limit communication with a researcher.

• Elderly Subjects
Persons over the age of 65 years of age.

• Emancipated Minor
A legal status conferred upon persons who have not yet attained the age of legal competency as defined by state law, but who are entitled to treatment as if they had by a virtue of assuming adult responsibilities.

• Emergency Use
Use of a test article on a human subject in a life-threatening situation in which no standard acceptable treatment is available and in which is not sufficient time to obtain IRB approval (21 CFR 50.27).

• Experimental Group
The Arm of a randomized trial that gets the new or “experimental” treatment. In some randomized trials, both of the treatments are standard treatments.

• Expired Studies
Studies that expire due to lack of continuing review. For more information, see IRB Policy 7.6 (Continuing Review).

• FDA Acknowledgment Letter
This letter typically comes 1-2 weeks after the FDA receipt of an IND submission. This letter assigns the IND number, gives the date of receipt, and reminds the sponsor-investigator of their obligations under the IND. This is NOT an approval to begin clinical trials. Clinical trials may not begin until 30 days after the IND receipt date or later if the IND is placed on clinical hold. The Sponsor-Investigator may or may not receive a letter permitting them to proceed with their trial. If a clinical hold is placed on the IND, the FDA should issue a letter detailing the IND deficiencies.
• Federal Oversight Body
Agencies to whom UAMS must report non-compliance according to the terms of the IRB Federalwide Assurance. These include the Office of Human Subjects Protection, the Food and Drug Administration, and the Office of Research Integrity.

• Federalwide Assurance (FWA)
Document, which formalizes an institution’s commitment to protect human subjects and is required by any institution that participates in Federally supported human subject research.

• Fetus
The product of conception from the time of implantation (as evidenced by any of the presumptive signs of pregnancy, such as missed menses, or a medically acceptable pregnancy test), until a determination is made, following expulsion or extraction of the fetus, that it is viable.

• Food and Drug Administration (FDA)
The U.S. Food and Drug Administration is a scientific, regulatory, and public health agency that oversees human and animal drugs, therapeutic agents of biological origin, medical devices, radiation-emitting products for consumer, medical, and occupational use, cosmetics, and animal feed. FDA scientists evaluate applications for new human drugs and biologies, complex medical devices, food and color additives, infant formulas, and animal drugs. It also monitors the manufacture, import, transport, storage, and sale of the aforementioned products as well as inspects facilities for compliance with regulations.

• Funding Source
An individual, pharmaceutical company, device manufacturer, government agency, academic institution, private or other organization that provides complete or partial financial, in kind, or other support for a research study.

• Good Clinical Practices (GCP)
International ethical and scientific quality standards for designing, conducting, monitoring, recording, auditing, analyzing, and reporting studies. Insures that the data reported is credible and accurate and that subject’s rights and confidentiality are protected.

• Guardian
An individual who is authorized under applicable state or local law to give permission on behalf of a child to general medical care [45 CFR 46.402 (3)]. May also apply to an individual who can provide consent for an incapacitated subject, cf., Surrogate.
• Human Subject (subject and participant used interchangeably)

1) An individual who is or becomes a participant in research either as a recipient of a test article or as a control;

2) A living individual about whom an investigator (whether professional or student) conducting research obtains:
   a. Data, of any kind, through intervention or interaction with the individual; OR
   b. Identifiable private information even in the absence of intervention or interaction.

• Human Subject Research

Any research that involves human subjects including any clinical investigation.

• Imminent Threat of an AE in Research

Any situation in which an adverse event in research has not yet occurred but is likely to occur, as determined by an IRB, research, or clinical team member, without preventative measures. Examples include potential harm to subjects due to stolen records and possible release of confidential data, or an error in research billing that puts the subject at potential financial harm.

• IND Monitoring Plan

Existing requirements for sponsors of clinical investigations involving new drugs for human and animal use (including biological products for human use) and medical devices under 21 CFR Parts 312 and 511, and 812 and 813, respectively, require that a sponsor or sponsor/investigator monitor the progress of a clinical investigation. The monitoring functions may be delegated to a contract research organization as defined under 21 CFR 312.3. Proper monitoring assures adequate protection of the rights of human and safety of all participants involved in clinical investigations and the quality and integrity of the resulting data submitted to the Food and Drug Administration (FDA). For more information, see IRB Policy 7.8 (IRB Oversight of Activities for Data Safety Monitoring).

• Informed Consent

The process of ongoing explanations to help a subject make educated decisions about whether to begin or continue participating in a research protocol or procedure.

• Informed Consent Document

A written summary of the research protocol (including its purpose, treatment procedures and schedule, potential risks and benefits, alternative to participation, etc.) and explanation of the rights of a research subject. Designed to begin the informed consent process.
• Inspection
Officially conducted audit by relevant authorities at the site of investigation and/or at the sponsor site to verify adherence to regulations.

• IRB Authorization Agreement
Formal, written agreement documenting the roles and responsibilities of Institution providing the IRB and Institution relying on the IRB.

• IRB of Record
IRB listed as an approved reviewing body for Institution’s research.

• Institutional Review Board
Any board, committee, or other group formally designated by an institution to review, to approve the initiation of, and to conduct periodic review of, biomedical research involving human subjects. The primary purpose of such review is to assure the protection of the rights and welfare of the human subjects [21 CFR 56.102(g)].

• Interaction
Includes communication or interpersonal contact between investigator and subject or participant.

• Intervention
Includes both physical procedures by which data are gathered (for example, venipuncture) and manipulations of the subject’s environment that are performed for research purposes.

• Investigational Agents
A pharmaceutical form of an active ingredient or placebo being tested or used as a reference in a clinical trial. This includes products with marketing authorization when they are formulated, packaged, or administered in a way different from the approved form, products used for off-label use, or products used to gain further information about an approved use (such as an unapproved population).

• Investigational Device
Any healthcare product that does not achieve its primary intended purposes by chemical action or by being metabolized. A medical device that is the subject of a clinical study designed to evaluate the effectiveness and/or safety of the device. Investigational use also includes clinical evaluation of certain modifications or new intended uses of legally marketed devices.
• **Investigational Drugs/Investigational Biologics**

A new drug or biological drug that is used in a clinical investigation. It also includes a biological product that is used in vitro for diagnostic purposes. Investigational drugs or biologics may include products that are not generally recognized as being safe and effective by the FDA or products already approved by the FDA as safe and effective for specific indications but are being studied for new indications, doses, strengths, dosing frequency, or in new populations. This latter description is known as off-label use.

• **Investigational Device Exemption (IDE)**

An FDA approved investigational device exemption (IDE) permits a device that otherwise would be required to comply with a performance standard or to have pre-market approval to be shipped lawfully for the purpose of conducting investigations of that device.

• **Investigational New Drug (IND)**

Current Federal law requires that a drug be the subject of an approved New Drug Application (NDA) before it is transported or distributed across state lines. Because a sponsor will probably want to ship the investigational drug to clinical investigators in other states, a sponsor must seek an exemption from that legal requirement. The IND is the means through which the sponsor technically obtains this exemption from the FDA.

• **Investigator (Principal Investigator)**

An individual who conducts an investigation, i.e., under whose immediate direction research is conducted, or, in the event of an investigation conducted by a team of individuals, is the responsible leader of that team.

• **In vitro fertilization**

Any fertilization of human ova which occurs outside the body of a female, either through admixture of donor human sperm and ova or by any other means.

• **Legally Authorized Representative (LAR)**

An individual or judicial or other body authorized under applicable law to consent on behalf of a prospective subject to the subject’s participation in the procedures involved in the research.

• **Life-Threatening**

Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted and diseases or conditions with potentially fatal outcomes, where the end point of clinical trial analysis is survival.
• Mature Minor
Someone who has not reached adulthood (as defined by state law) but who may be treated as an adult for certain purposes (e.g., consenting to medical care). Note that a mature minor is not necessarily an emancipated minor.

• Minimal Risk
A risk is minimal where the probability and magnitude of harm or discomfort anticipated in the proposed research are not greater, in and of themselves, than those ordinarily encountered in daily life or during the performance of routine physical or psychological examinations or tests. For example, the risk of drawing a small amount of blood from a healthy individual for research purposes is no greater than the risk of doing so as part of routine physical examination.

• Multi-center
Refers to a study that is being done at several hospitals or institutions simultaneously.

• Non-compliance
Failure to comply with applicable Federal Regulations, UAMS IRB policies and procedures, UAMS and/or other institutional policies and procedures, or the determinations of the UAMS IRB.

• Non-Human Subject Research
An activity determined by the IRB to not meet the definitions of Human Subject Research as per this policy.

• Non-Significant Risk (NSR) Device
A device that does not meet the definition of a significant risk device.

• Non-Significant Risk (NSR) Device Study
A study of a device that does not meet the definition for a significant risk device and does not present a potential for serious risk to the health, safety, or welfare of participants. NSR device studies should not be confused with the concept of "minimal risk”.

• Nonviable Fetus
A fetus ex utero, which, although living, is not viable.
• Pediatric Risk Category I
Minimal Risk.

• Pediatric Risk Category II
Greater than minimal risk, but presenting the prospect of direct benefit to individual participants.

• Pediatric Risk Category III
Greater than minimal risk and no prospect of direct benefit to individual participants but likely to yield important generalizable knowledge about the participant’s disorder or condition.

• Pediatric Risk Category IV
Otherwise not approvable, but presents an opportunity to understand serious health or welfare problems of children.

• Permission
The agreement of parent(s) or guardian to the participation of their child or ward in research [45 CFR 46.402 (c)].

• Placebo
An inert substance, such as a sugar pill.

• Pregnancy
Encompasses the period of time from confirmation of implantation (through any of the presumptive signs of pregnancy, such as missed menses, or by a medically acceptable pregnancy test), until expulsion or extraction of the fetus.

• Prisoner
Any person who is sentenced to a penal institution under a criminal or civil statute as well as individuals detained in other facilities by virtue of statutes or commitment procedures, which provide alternatives to criminal prosecution or incarceration in a penal institution [45 CFR 46.303(c)].
• Private Information
Information about behavior that occurs in a context in which an individual can reasonable expect that no observation or recording is taking place; and Information which has been provided for specific purposes by an individual and which the individual can reasonably expect will not be made public (for example, Medical records). Private Information must be individually identifiable (identity of subject is or may readily be ascertained or associated with the information) in order to constitute research involving human subjects.

• Protocol
A document, which states the rationale, objectives and statistical design and methodology of the trial, with the conditions under which it, is to be performed and managed.

• Protocol Deviation
An unplanned or unforeseen change in an ongoing study that is not covered under an approved IRB protocol.

• Protocol Violation
An unplanned or unforeseen change in an ongoing study that is not covered under an approved IRB protocol. Usually represents a more serious non-compliance problem than a protocol deviation and is noted after the fact or based on a technical error resulting in the protocol or standard operating procedure not being followed.

• Randomized Trial
A clinical trial with at least two arms, in which the decision as to which arm a new subject is assigned, is made by change, for instance, by the flip of a coin or by using a computer to select randomly.

• Related Event
An event is “related” if it is likely to have been caused by the research activity

• Research
A systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge.

• Risk
The probability of harm or injury (physical, psychological, social, or economic) occurring as a result of participation in a research study. Both the probability and magnitude of possible harm may vary from minimal to significant. Federal regulations define only "minimal risk."

- **Scientific Misconduct**
  Fabrication, falsification, or plagiarism in proposing, performing or reviewing research, or in reporting research results.

- **Serious Adverse Event**
  Any adverse event that results in any of the following outcomes; death, a life-threatening adverse event, inpatient hospitalization or prolongation of existing hospitalization, a persistent or significant disability/incapacity, or a congenital anomaly/birth defect. Important medical events that may not result in death, be life-threatening, or require hospitalization may be considered a serious adverse event. When, based upon appropriate medical judgment, they may jeopardize the subject any may require medial or surgical intervention to prevent one of the outcomes listed in this definition. Examples of such medical events include allergic bronchospasm requiring intensive treatment in an emergency room or at home, blood dyscrasias or convulsions that do not result in inpatient hospitalization, or the development of drug dependency or drug abuse. Additional examples may include suicidal ideation or attempts, and unintentional revealing of some genetic information to insurers.

- **Serious Event**
  An event is “serious” if it involves considerable detriment to one or more persons (who may or may not be subjects), or required intervention to prevent one or more persons from experiencing considerable detriment or harm.

- **Serious Non-compliance**
  An action or omission taken by an Investigator (or study personnel) that any other reasonable Investigator would have foreseen as compromising the rights and/or welfare of a subject.

- **Significant Risk (SR) Device**
  A device that presents a potential for serious risk to the health, safety, or welfare of a subject and (1) is an impact; or (2) is used in supporting or sustaining human life; or (3) is of substantial importance in diagnosing, curing, mitigating or treating disease, or otherwise prevents impairment of human health; or (4) otherwise presents a potential for serious risk to the health, safety, or welfare of a subject (21 CFR Part 812).

- **Significant Risk (SR) Device Study**
A study of a device that presents a potential for serious risk to the health, safety, or welfare of a participant and 1) is intended as an implant; 2) is used in supporting or sustaining human life; or otherwise prevents impairment of human health; 3) is of substantial importance in diagnosing, curing, mitigating or treating disease, or otherwise prevents impairment of human health; or 4) otherwise presents a potential for serious risk to the health, safety, or welfare of a participant.

- **Sponsor**

Any person or entity that takes responsibility for and initiates a research study. The sponsor may be an individual, pharmaceutical company, device manufacturer, governmental agency, academic institution, private organization, or other organization.

- **Sponsor/Investigator**

An individual who both initiates and conducts an investigation, and under whose immediate direction the investigational drug is administered or dispensed. The term does not include any person other than an individual. The FDA requirements applicable to a sponsor-investigator under this part include both those applicable to an investigator and a sponsor.

- **Standard**

A broad description of performance expectation.

- **Standard Operating Procedures (SOPs)**

Detailed, written procedures for the uniform performance of a function. These are the standard procedures that trained study personnel must follow to ensure the quality and integrity of the work performed during a study.

- **Substantive Action by the IRB**

An action taken by the IRB that materially alters the substance and meaning of a protocol, informed consent form or process, or investigator status, including, but not limited to, restriction, suspension or termination of a study or investigator participation, and actions taken to prevent future occurrence(s) of the AE in research.

- **Surrogate**

A person that can provide legal consent for an incapacitated subject, cf. Guardian.

- **Suspended for Cause**

An action initiated by the IRB to temporarily stop some or all research procedures until the outlined requirements are met.
• Tabled
Serious deficiencies in submitted protocol, continuing review or modification with issues to be addressed by the investigator and reviewed by the full IRB before the IRB can grant approval. The PI will be provided with contingencies to explain rationale for Tabled decision. PIs should be aware that the IRB upon receiving the responses to a tabled protocol may have additional requested revisions.

• Terminated for Cause
An action initiated by the IRB to permanently stop some or all research procedures

• Test Article
Any drug (including a biological product for human use), medical device for human use, human food additive, color additive, electronic product or any other article subject to FDA regulations.

• Treatment IDE
A mechanism through the FDA for providing eligible participants with investigational devices for the treatment of a serious or life-threatening illness for which there are no satisfactory alternatives.

• Unanticipated Adverse Device Effect
Any serious adverse effect on health or safety or any life-threatening problem or death caused by, or associated with, a device, if that effect, problem, or death was not previously identified in nature, severity, or degree of incidence in the investigational plan or application (including a supplementary plan or application), or any other unanticipated serious problem to participants or others associated with a device that relates to the rights, safety, or welfare of participants.

• Unanticipated Event
An event is “unexpected” when its specificity, nature, severity or incidence are not accurately reflected in the information previously reviewed and approved by the IRB.

• Unanticipated Problem Involving Risks to Participants or Others
Any event that was serious, unanticipated and related to the research
• Unexpected Adverse Event
Any adverse event not specified in or not consistent with the risk information in the protocol, investigator’s brochure or device manual. Unexpected, as used in this definition, refers to an adverse event that has not been previously observed.

• Unexpected Event
Any adverse event not specified in or not consistent with the risk information in the protocol, investigator’s brochure or device manual. Unexpected, as used in this definition, refers to an adverse event that has not been previously observed.

• Viable
As it pertains to the fetus means being able, after either spontaneous or induced delivery, to survive (given the benefit of available medical therapy) to the point of independently maintaining heartbeat and respiration. If a fetus is viable after delivery, it is a premature infant.

• Vulnerable Subjects
Individuals whose willingness to volunteer in a research study may be unduly influenced or coerced; and individuals with limited autonomy. These individuals may include, but are not limited to, children, prisoners, pregnant women, mentally disabled, or economically or educationally disadvantaged persons.

• Waiver
A request to FDA to waive applicable requirements under 21 CFR 312 – Investigational New Drug Application.
CHAPTER 20

Abbreviations

This section contains abbreviations.
Abbreviations

Arkansas Area Health Education Centers  AHEC
Arkansas Cancer Research Center  ACRC
Arkansas Children’s Hospital  ACH
Arkansas Children’s Hospital Research Institute  ACHRI
Arkansas Department of Health  ADH
Arkansas State Hospital  ASH
Automated Research Information Administration  ARIA
Case Reporting Forms  CRF
Central Arkansas Veterans Healthcare System  CAVHS
Code of Federal Regulations  CFR
Continuing Review Record  CRR
Food and Drug Administration  FDA
Federal-wide Assurance  FWA
General Clinical Research Center  GCRC
Good Clinical Practice  GCP
Health and Human Services  HHS
Health Insurance Portability and Accountability Act of 1996  HIPAA
Human Subject Training  HST
Institutional Review Board  IRB
International Conference on Harmonisation  ICH
Investigational New Drug  IND
Multiple Project Assurance  MPA
National Institutes of Health  NIH
Office for Human Research Protections  OHRP
Office of Research and Sponsored Programs  ORSP
Office of Research Oversight  ORO
Principal Investigator  PI
Protocol Review and Monitoring Committee  PRMC
University of Arkansas for Medical Sciences  UAMS
UAMS Biosafety Committee  UBC
VA Research and Development  VA R/D
CHAPTER 21

Resource List of Committees and Institutional Contacts

This section contains the contact information for Arkansas Children’s Hospital (ACH), Arkansas Children’s Hospital Research Institute (ACHRI), Central Arkansas Veterans Healthcare System (CAVHS), and university of Arkansas for Medical Sciences (UAMS).

Arkansas Children’s Hospital
Arkansas Children’s Hospital Research Institute
Central Arkansas Veterans Healthcare System
University of Arkansas for Medical Sciences
**ARKANSAS CHILDREN'S HOSPITAL (ACH) website**

<table>
<thead>
<tr>
<th>Service</th>
<th>Phone Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main Number</td>
<td>(501) 364-1100 (Phone)</td>
</tr>
<tr>
<td>Research Pharmacy</td>
<td>(501) 364-2596 (Phone)</td>
</tr>
<tr>
<td></td>
<td>(501) 364-2595 (Fax)</td>
</tr>
<tr>
<td>Pediatric Clinical Research Unit</td>
<td>(501) 364-2338 (Phone)</td>
</tr>
<tr>
<td>Radiation Safety Committee</td>
<td>(501) 364-3800 (Phone)</td>
</tr>
</tbody>
</table>

**ARKANSAS CHILDREN’S HOSPITAL RESEARCH INSTITUTE (ACHRI) website**

<table>
<thead>
<tr>
<th>Service</th>
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<tbody>
<tr>
<td>Assistance with IRB Submissions, ARIA, and HIPAA</td>
<td>(501) 364-3571 (phone)</td>
</tr>
<tr>
<td>Clinical Trials (Pharmaceutical/Industry), Confidentiality and Study Agreements</td>
<td>(501) 364-2705 (Fax)</td>
</tr>
<tr>
<td>CUMG Awards</td>
<td>(501) 364-3581 (Phone)</td>
</tr>
<tr>
<td>Federal and Private Grants</td>
<td></td>
</tr>
<tr>
<td>Pediatric Clinical Research Unit Coordinator</td>
<td>(501) 364-2760 (phone)</td>
</tr>
<tr>
<td>Procedure Prices for Research</td>
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<tr>
<td>Research Coordinator Pool</td>
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<tr>
<td>Subject Tracking System</td>
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</tr>
<tr>
<td>Manuscript Grant Writing/Editing</td>
<td>(501) 364-2469 (Phone)</td>
</tr>
<tr>
<td>Grants Accounting</td>
<td>(501) 364-2513 (Phone)</td>
</tr>
<tr>
<td>Research Compliance Specialist/Education Coordinator</td>
<td>(501) 364-2862 (Phone)</td>
</tr>
<tr>
<td>Research Computer Systems</td>
<td>(501) 364-6546 (Phone)</td>
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**CENTRAL ARKANSAS VETERANS HEALTHCARE SYSTEM (CAVHS) website**

<table>
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<tr>
<td>Main Number</td>
<td>(501) 257-1000 (Phone)</td>
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<tr>
<td>Biomedical Research Foundation</td>
<td>(501) 257-4517 (Phone)</td>
</tr>
<tr>
<td></td>
<td>(501) 257-4623 (Fax)</td>
</tr>
<tr>
<td>Subcommittee for Research Safety</td>
<td>(501) 257-4816 (Phone)</td>
</tr>
<tr>
<td></td>
<td>(501) 257-4821 (Fax)</td>
</tr>
<tr>
<td>Radiation Safety Committee</td>
<td>(501) 257-6108 (Phone)</td>
</tr>
<tr>
<td>Research Compliance Office</td>
<td>(501) 257-5558 (Phone)</td>
</tr>
<tr>
<td></td>
<td>(501) 257-4821 (Fax)</td>
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<tr>
<td>Research &amp; Development Committee</td>
<td>(501) 257-4816 (Phone)</td>
</tr>
<tr>
<td></td>
<td>(501) 257-4821 (Fax)</td>
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<tr>
<td>Research Pharmacy</td>
<td>(501) 257-6338 (Phone)</td>
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<td>(501) 257-6339 (Fax)</td>
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**VA Research website**
### University of Arkansas for Medical Sciences (UAMS) website

<table>
<thead>
<tr>
<th>Committee/Person</th>
<th>Phone Numbers</th>
<th>Fax Numbers</th>
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<tbody>
<tr>
<td>Main Number</td>
<td>(501) 686-7000 (Phone)</td>
<td></td>
</tr>
<tr>
<td>Animal Research Committee</td>
<td>(501) 686-5347 (Phone)</td>
<td></td>
</tr>
<tr>
<td>Biosafety Committee, Dr. Lee Soderberg</td>
<td>(501) 686-6368 (Phone)</td>
<td></td>
</tr>
<tr>
<td>Biohazards Committee</td>
<td></td>
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<tr>
<td>DNA Committee</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr. Charles Winter, Associate Dean of Research</td>
<td>(501) 686-5347 (Phone)</td>
<td>(501) 686-8501 (Fax)</td>
</tr>
<tr>
<td>College of Medicine</td>
<td></td>
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</tr>
<tr>
<td>General Clinical Research Center (GCRC)</td>
<td>(501) 257-5399 (Phone)</td>
<td>(501) 257-5817 (Fax)</td>
</tr>
<tr>
<td>Steven C. Elbein, MD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professor of Medicine, Program Director</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suzanne Ritter Lumpkin, MS, JD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GCRC Administrator</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Institutional Review Board (IRB)</td>
<td>(501) 686-5667 (Phone)</td>
<td>(501) 686-7265 (Fax)</td>
</tr>
<tr>
<td>Including ARIA Usernames/Passwords</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jennifer Sharp</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Associate Director, ORSP</td>
<td>501-686-8062</td>
<td></td>
</tr>
<tr>
<td>Office for Clinical Trials Dr. Thomas G. Wells, Director</td>
<td>(501) 686-8572 (Phone)</td>
<td>(501) 686-8501 (Fax)</td>
</tr>
<tr>
<td>Julia Washam, R.N.</td>
<td></td>
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<tr>
<td>Liaison Specialist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office of Research and Sponsored Programs</td>
<td>(501) 686-5502 (Phone)</td>
<td>(501) 686-8359 (Fax)</td>
</tr>
<tr>
<td>Tim Atkinson, Director</td>
<td></td>
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<tr>
<td>Research Privacy Officer</td>
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<td></td>
</tr>
<tr>
<td>Office of Research Compliance Danna K. Carver, Director</td>
<td>(501) 526-6876 (Phone)</td>
<td>(501) 526-6272 (Fax)</td>
</tr>
<tr>
<td>Kevin Simmons, UAMS Compliance Educator</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pharmacy Committee</td>
<td>(501) 686-6220 (Phone)</td>
<td>(501) 296-1133 (Fax)</td>
</tr>
<tr>
<td>Mike Parr, Pharm.D.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Protocol Review &amp; Monitoring Committee (PRMC) Angie Smith, LCSW, CRA</td>
<td>(501) 686-8274 (Phone)</td>
<td>(501) 296-1466 (Fax)</td>
</tr>
<tr>
<td>PRMC Administrator</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Radiation Safety Committee</td>
<td>(501) 686-5299 (Phone)</td>
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</tbody>
</table>
Office of Research Compliance Homepage

The primary purpose of the Office of Research Compliance is to support those activities that protect human research subjects and elevates the general level of research through systematic evaluation of research activities.

The main functions of the ORC include Auditing, Education and Advisory Consultation efforts that promote research compliance and integrity.

The ORC functions as the auditing and compliance body for the UAMS Institutional Review Board. Our office is a component of the campus Human Research Protections Program (HRPP). ORC reports directly to the senior campus research official, the Vice Chancellor for Academic Affairs and Research Administration.

To find out more about the Office of Research Compliance click on the About ORC button to the left.

Announcements

October 2005 Coordinator's Training - at the VA. Click here to register

Investigator's Handbook. Click here to download.

New Links

OHRP - Assurance page
OHRP - Registration of an Institutional Review Board (IRB) or Independent Ethics Committee (IEC)
OHRP - Policy Guidance by topics
Research use of radioactive agents and when an IND is NOT needed.
Protocol Writing Guideline (Word Document)

Click here for the MANDATORY EDUCATION POLICY FOR INVESTIGATORS/STUDY PERSONNEL PARTICIPATING IN HUMAN SUBJECT RESEARCH PROJECTS

HIPAA for Research TRAINING

Click on the text above for the course you want.

http://www.uams.edu/orc/
Faculty Resources

D. Support Units and Services

Educational Support Policies

- Audio-Visual Services (Admin Policy 12.2.01)
- Digital Imaging Services (Admin Policy 12.2.03)
- Graphics and Medical Art (Admin Policy 12.2.04)
- Instructional Equipment Repair (Admin Policy 12.2.02)
- Instructional Television (Admin Policy 12.2.05)
- Photographic Services (Admin Policy 12.2.06)
- Printing Services (Admin Policy 12.2.07)
- Use of Images (Admin Policy 12.2.08)
- UAMS Institutional Policy on the Use of Copyrighted Materials (Admin Memorandum 12.0.2)

University-wide Instruction Support Units

- Academic Computing
- Clinical Skills Center
- Office of Academic Services
- Office of Educational Development
- UAMS Library
  - Learning Resource Center - Teaching Research Center, Teaching & Technology Committee, Friday @ Noon Series
  - Teaching Resource Center
  - ACH Library

Each college also features support and services for its teaching faculty. For more information please contact your Dean's office.

Other

- Computer Training Center - classroom training on campus information systems
- Creative Services - ID badges, business cards, stationary, printing, scientific posters
- Employee Assistance Program - employee counseling services
- Employee/Student Health Clinic - health screenings and records
- Fitness Center - employee & student weight & aerobic fitness area
- Information Technology - computer support
- Parking - Apply for paid parking on campus
- Telecommunications - telephone, wireless phone, blackberries
- Professional Staff Office - Medical licensing and credentialing
- Web Mail - Access UAMS Outlook email from a web browser.

Special Primary Care Services for Employees and Their Families (Preferred Primary Care Clinic 686-6560)
POLICY

The purpose of this policy is to inform departments within the University of Arkansas for Medical Sciences (UAMS) of the audio-visual services available through the Office of Educational Services.

PROCEDURE

1. The Audio-Visual Office is located in the Educational II Building, Room B-143. The office operates on a Monday-Thursday daily schedule of 7:30 a.m. to 10:00 p.m. and Fridays 7:30 a.m. to 6:00 p.m. Audio-Visual personnel are available from 6:30 a.m. to 10:00 p.m. Monday through Thursday and Fridays 6:30 a.m. to 6:00 p.m. Audio-Visual technicians are on "standby" to support weekend functions.

2. Audio-visual equipment and projectionist/technical services can be requested by calling extension 65575 or by providing the vital information on the UAMS Meeting Room/Audio/Visual Equipment Reservation Form provided by the Office of Educational Services. Faculty and staff requesting less than 24 hours in advance may be required to obtain the equipment in person on a checkout basis during periods of peak activity.

3. The following UAMS areas are designated for delivery of audio-visual equipment: Administration-Conference Rooms A, B, B-2, C, Education II-All locations, Hospital-M1034, 4D27, 8001, and Shorey-Auditorium, 2S02G, 8025.

4. One-time meetings requiring Audio-Visual equipment or services in rooms not listed in (3) should be submitted to the supervisor of Audio-Visual Services for approval at least 24 hours prior to the meeting. Delivery is contingent upon available equipment and personnel.

5. Regularly scheduled meetings requiring Audio-Visual equipment or services in rooms not listed in (3) should be submitted in writing to Slot 615, at least two weeks prior to the meeting.

6. The Audio-Visual Services supports an emergency line dedicated for use in reporting, emergencies, for example equipment failures and lamps burn-outs. The Emergency Line answered by Audio-Visual technicians is extension 6555. Non-emergency communications should be directed through 65575.

7. The Audio-Visual Services provides the following services: Delivery and distribution of requested audio-visual equipment, set-up and testing of equipment, assistance and instruction in the operation of the visual equipment, retrieval of equipment, projectionist/technical support upon request, loan of audio-visual equipment, and repair and preventive maintenance of audio-visual equipment.

8. Loan of audio-visual equipment is available through the Audio-Visual Services. Equipment is loaned out for use in UAMS-associated activities by faculty or staff on an overnight basis or for extended periods. The borrower assumes full responsibility for the equipment, and will be required to provide a UAMS account number prior to checkout to be used in the event of loss or damage to the equipment. Replacement bulbs are routinely checked out with projectors, and must be returned. In the event of a burn-out, the burned-out bulb should be returned to avoid replacement charges.

9. All Audio-Visual equipment includes a 20 foot AC extension cord and an appropriate cart or travel case is supplied.

10. For additional information concerning the Audio-Visual Services, contact extension 65575.

OES MEETING ROOM & AUDIOVISUAL EQUIPMENT RESERVATION INSTRUCTIONS

GENERAL INFORMATION

Departments must complete the OES Meeting Room & Audiovisual Equipment Reservation Form when requesting a OES meeting room and/or audiovisual equipment. Forms are available through OES, extension 65575. Return completed form to OES, slot 615. Room or Audiovisual requests may also be made by accessing the VAX mainframe computer. At the "$" prompt type the word "Room". On-line
COMPLETING THE FORM

1. **Room**: Enter the specific location of the room.
2. **AV Requested**: Indicate the space provided the type(s) of audio-visual requested. Refer to the OES User’s Guide for descriptions of equipment or contact 65575.
3. **Acct.#**: Enter the requesting department’s account number.
4. **Special TV Requirements**: Enter the special TV requirements related to the request.
5. **Call**: Check appropriate space for a confirmation call placed by the OES staff regarding this request.
6. **Today’s Date**: Enter the current date.
7. **Time**: Enter the time in which this request form is completed.
8. **Initials**: Enter the requester’s initials in the space provided.
9. **Requester’s Name**: Enter the name of the requester.
10. **Host/Moderator’s Name**: Enter the name of the host or moderator.
11. **Department/College/Unit**: Enter the name of the requesting department, college, or unit.
12. **Phone**: Enter the telephone number of the requester.
13. **Mail Slot**: Enter the mail slot number of the requester.
14. **Course/Meeting Description**: Enter a description of the course or meeting related to the request.
15. **Estimated Number of Participants**: Enter the estimated number of participants.
16. **Start Date**: Enter the first day of the event.
17. **End Date**: Enter the last day of the event.
18. **Days of Week**: Enter the days of the week associated with the event.
19. **Meeting Times**: Enter the times the event will begin and end.
20. **If this is not a weekly event, please enter dates needed**: Enter the dates of the event.
21. **Request Room Number**: Enter the number of the room requested.
The purpose of this policy is to inform departments within the University of Arkansas for Medical Sciences (UAMS) of the digital imaging services available through the Office of Educational Services.

PROCEDURE

1. The Digital Imaging Service is located in the Education II Building, room B-142. Operating hours are 8:00 a.m. to 4:30 p.m. Monday through Friday.
2. Digital Imaging Services are available to official UAMS users as first priority on a fee for service basis. Services are offered to non-UAMS clients on a secondary priority basis.
3. Services include consultation on software selection and application; assistance with PC setup of graphics software packages, color palette and device driver installation; creation of high resolution 35mm color slides; imaging of client-created slides, with or without enhancement by Media Services personnel; and instruction in the use of graphics software packages supported.
4. The Office of Educational Services recommends that departments consult Media Services personnel before the purchase of any graphics software intended to produce color slides.
5. For additional information on digital imaging services, call 686-5570.
PURPOSE

The purpose of this policy is to inform departments within the University of Arkansas for Medical Sciences (UAMS) of the graphics and medical art services available through the Office of Educational Services.

PROCEDURE

1. The Graphics and Medical Art Unit operates on a year-round schedule of 8:00 a.m. to 4:30 p.m., Monday through Friday. Offices and studios are located in the Education II Building, B-142.
2. Professional staff are available for job receiving and consultation on a drop-in basis. For major project planning and discussion which may require special attention, however, advance appointment is recommended.
3. Services include textbook and journal illustrations; audio-visual projects; exhibits and displays; scientific posters; brochures; calligraphy; organizational charts, maps, logos; stationery and letterhead; architectural drawings; certificates; business forms; charts and graphs; typesetting services and miscellaneous print media preparation; coordination and bidding of printing; and consultation.
4. For additional information about Graphics and Medical Art, call 686-5570.
The purpose of this policy is to inform departments within the University of Arkansas for Medical Sciences (UAMS) of the procedures to follow for instructional equipment repair available through the Office of Educational Services.

PROCEDURE

1. The Office of Educational Services maintains its own scientific instrumentation repair shop for the purpose of supporting all OES units.
2. Priority is given to repair of equipment (laboratory, AV, TV) utilized in direct support of the educational programs of the UAMS colleges.
3. The Office of Educational Services recommends departments to report repairs of research instrumentation to the Instrumentation Lab in Physical Plant at extension 65754.
4. The Office of Educational Services Instrumentation Engineer is available, schedule permitting, for consultation and equipment repair at extension 65575.
5. For a list of current charges for equipment repair, call 65575.
PURPOSE

The purpose of this policy is to inform departments within the University of Arkansas for Medical Sciences (UAMS) of the printing services available through the Office of Educational Services.

PROCEDURE

1. The Instructional Television main facility is located in Education II, B-142. Remote studios in the 8th and 9th floor teaching labs are also maintained. Normal operating hours during the academic year are 8:00 a.m. to 4:30 p.m.

2. The AV/TV emergency line, extension 6555 may be used in cases of urgent need requiring immediate action, and is answered during normal operating hours by AV or TV personnel. Reports of loss of TV signal, equipment malfunctions during use, picture/sound interference on this line will provide the user with direct contact with technically-qualified personnel. For all other communications, call extension 65570.

3. Services include video tape production in studio or "on location": video dubbing and tape duplication; video conversion to other formats (BETA, VHS); audio recording for TV, radio broadcast use, AVE presentation; audio tape mastering, dubbing and synchronization; computer-generated titling; audio and video editing service; consultation, preventative maintenance and minor equipment repairs, post production, 3/4" and 1/2" editing with Digital Video Effects (DVE).

4. For additional information and lists of current charges on Instructional Television, call 65570.
PURPOSE

The purpose of this policy is to inform departments within the University of Arkansas for Medical Sciences (UAMS) of the photographic services available through the Office of Educational Services.

PROCEDURE

1. Photographic Services is located in Education II, B-142 with studios in Education II, G-102. Operating hours are 8:00 a.m. to 4:30 p.m., Monday through Friday.
2. Photographic Services are provided to official UAMS users as a first priority on a fee-for-service basis. Services not chargeable to a UAMS account are provided on a second priority basis to users professionally associated with UAMS or from the health care community at large with needs for the specialized services offered.
3. After-hours photographic needs may be scheduled with advance notice. Off-campus travel after hours will normally incur additional charges as appropriate.
4. Emergency needs for photography outside normal operating hours are provided for with equipment support. On a daily basis, Photographic Services places a “camera kit” at the ER nursing station. The kit contains camera and flash equipment ready for use, simplified instructions for use, and necessary forms for documentation. At the open of business on the next working day, the kits are collected, exposed film is processed and delivered normally to the client. Equipment is given an operational check and reloaded with fresh film daily.
5. Services include preparation of 35mm teaching slides; preparation of prints for publication; portraits, application and passport photos; UAMS employee ID cards; photography of studio setups (instrument arrays, etc.); surgical/clinical photography; technical/scientific photography; photomicrography; public relations and general illustrative photography; student and faculty yearbook photo/class composites; slide duplication; film processing and miscellaneous photolab services; luggage tags; transparencies, and photo copies.
6. For additional information and lists of current charges on photographic services, call 686-5570.
PURPOSE

The purpose of this policy is to inform departments within the University of Arkansas for Medical Sciences (UAMS) of the printing services available through the Office of Educational Services.

PROCEDURE

1. Printing Services is located in the Distribution Center, Room 116. Normal hours of operation are 8:00 a.m. to 4:30 p.m., Monday through Friday.
2. A "quick copy" service is offered for certain duplicating jobs which qualify, by high-speed Xerography. Offset printing on a wide variety of paper stocks and a variety of ink colors is available.
3. The printing services available are printing and binding of: course manuals, stockroom forms, medical records forms, memo pads, letterheads, NCR sets, brochures, bulletins, newsletters, calendars, multiple copies of grant applications, course manuals, invitations, announcements and programs.
4. Tests and exams are given priority treatment and produced by high-speed Xerox.
5. Grant applications will be given priority treatment through the high-speed Xerox.
6. Contact Printing Services at extension 686-5574 for additional information and lists of current charges on printing services.
   Departments are encouraged to call in advance to arrange for while-you-wait production, on a same-day basis.
UAMS ADMINISTRATIVE GUIDE

NUMBER: 12.2.08
DATE: 08/17/00
REVISION:

SECTION: ACADEMIC AFFAIRS
AREA: EDUCATIONAL SERVICES/MEDIA SERVICES
SUBJECT: USE OF IMAGES

PURPOSE

Media Services provides both technical and general photography services to UAMS faculty, staff and students. The department also produces photographic images on its own from time to time for general use in illustrating various UAMS publications. This policy describes how images will be stored and made available for use of the UAMS community.

POLICY

Photographic and digital images created by Media Services people in the course of their work and funded with university funds are the property of the University of Arkansas and are copyrighted by the university at the moment of creation. General-purpose images that belong to the University should be made available for official use to the entire UAMS community.

PROCEDURE

I. IMAGE CAPTURE

A. UAMS patients are photographed only at the request of a UAMS physician. Patients are not photographed in a manner that allows them to be recognized from the photo unless a valid patient release has been secured. Informed consent is the responsibility of the ordering physician. Media Services personnel responsibility is limited to obtaining an authorizing signature or verifying that such a document exists.

B. Model releases will be obtained by Media Services people when necessary. Model releases are not necessary when photographing students and employees of UAMS performing normal activities for their position or status.

C. Media Services will maintain files of patient and model releases.

D. Generally, original images are archived in Media Services and duplicates or copies are provided to the customer.

II. Image recording and filing

A. General purpose images that may have future use potential will be stored by Media Services in a secure manner to protect them from damage and extend their life span in the UAMS Image Bank. Current practice is to digitally scan images at low resolution when added to the collection and index records through an asset management data base that allows the collection to be searched and images viewed without handling the original image.

B. The following data are recorded when an image is added to the UAMS Image Bank:

1. Date of image capture
2. Category keywords to enable image retrieval
3. Names of recognizable people and / or places in the image
4. A description of the activity pictured in the image
5. Notes of any restrictions that may apply to future use of the image (see below)

C. Subject to the restrictions described below, images in the UAMS Image Bank are available to all UAMS people,
who may place orders for the use of images for official university purposes. Prints, copies or duplicates will be provided by Media Services at an appropriate price.

D. Also subject to the restrictions described below, non-UAMS people or entities may also place orders for images stored in the UAMS Image Bank, and orders may be fulfilled when deemed to be in the best interest of the university. Prints, copies or duplicates will be provided by Media Services at an appropriate price. In addition to the restrictions described below, the university reserves the right to refuse any requests for use of images.

III. Restrictions

A. Patient photographs are released only to the requesting physician or to the Department of Health Information Management (Medical Records) at the physician’s request. Images with teaching value may be stored in a restricted area of the UAMS Image Bank if permitted by the ordering physician and the patient’s release.

B. General-purpose images acquired by Media Services professionals acting on their own initiative are normally added to the UAMS Image Bank as soon as they’re catalogued.

C. General-purpose and/or biomedical images commissioned by UAMS clients for the purpose of scholarly publication (e.g. journal article, textbook illustrations, etc.) are considered the author’s intellectual property in accordance with University of Arkansas Patent and Copyright Policy. Such images may be added to the UAMS Image Bank at the author’s option and with any additional restrictions for use that may be specified by the author.

D. General-purpose images "made for hire" (i.e., a UAMS department pays Media Services with university funds to create the image) are considered the property of the University of Arkansas rather than of the specific UAMS entity that commissioned their creation. However, it’s recognized that in some cases overuse of an image may compromise the effectiveness of a publication or a campaign. In those cases, the department may request that an image be excluded from the UAMS Image Bank until a certain "exclusive use" period of time has elapsed. Unless an "exclusive use" period is requested, images "made for hire" are added to the UAMS Image Bank as soon as they’re catalogued.

It will be the responsibility of Media Services to verify that general-purpose images produced may be used without "exclusive use" restrictions. Requests for periods of exclusive use exceeding six months will be presented to the Media Services Advisory Committee for a recommendation.

E. Other restrictions or conditions that may be requested by the customer will be presented to the Media Services Advisory Committee for a recommendation.
UAMS Institutional Policy on the Use of Copyrighted Materials

Administrative Guide 12.0.2

The University of Arkansas for Medical Sciences is an accredited nonprofit educational institution supporting the activities of educators, scholars, researchers, and students. UAMS promotes an environment of compliance with copyright laws through the campus-wide distribution of the Guidelines for UAMS Faculty, Staff, and Students Using Copyrighted Materials throughout the Colleges and the educational support units.

UAMS promotes the educational and research use of copyrighted materials (Appendix A. Basic Copyright Law) through the appropriate application of the provisions provided in copyright law for fair use (Appendix B. Fair Use) and for specific exemptions granted for educational and research purposes (Appendix C. Exemptions). At this time, exemptions include the Teaching Exemption, the provisions for distance education covered by the Technology, Education, and Copyright Harmonization Act (TEACH Act), and special Library Exemptions. UAMS observes ‘best practices’ and ‘guidelines’ commonly accepted within the academic community (Appendix D. Guidelines).

The Institutional Responsibilities of UAMS (Appendix E) document addresses the institutional administrative and technological responsibilities required to take advantage of fair use and exemptions.

These institutional policies and guidelines were approved the UAMS Chancellor’s Cabinet, the UAMS Administrative Council, and Harold Evans, JD, of Williams and Anderson LLP.

Guidelines for UAMS Faculty, Staff, and Students Using Copyrighted Materials
Teaching in the Face-to-Face Classroom (Teaching Exemption)
Fair Use for Teaching Faculty and Students at UAMS
Distance Education and TEACH Act
Course Management Software (WebCT) and E-Reserves
Fair Use of Digital Images
Fair Use for Scholarship and Research

College of Medicine Guidelines for Use of Copyrighted Materials in Education
Brief guidelines designed to alert teaching faculty to copyright issues.
(Also adopted by the College of Nursing and College of Pharmacy)

Appendices: Summaries of copyright law and guidelines
Appendix A. Basic Copyright Law - 17 U.S. Code 102
Copyright from the code

Appendix B. Fair Use - 17 U.S. Code Section 107

Appendix C. Exemptions
Teaching Exemption - 17 U.S.Code 110(1)
Library Exemptions (17 U.S. Code 108)

Appendix D. Guidelines
Educational Fair Use Guidelines for Digital Images
http://www.utsystem.edu/ogc/intellectualproperty/copypol2.htm
Guidelines for Classroom Copying of Books and Periodicals
http://www.utsystem.edu/ogc/intellectualproperty/clasguid.htm

Appendix E. Institutional Responsibilities of UAMS

http://www.library.uams.edu/policy/copyright.aspx
For questions and assistance, please contact the Library Assistant Director (Jan Hart, Ed.D., 686-6751, hartjanicek@uams.edu). Questions requiring additional attention will be forward to designated UAMS counsel. UAMS faculty, students, and staff are directed to the University of Texas System Crash Course in Copyright http://www.utsystem.edu/ogc/intellectualproperty/cprtindx.htm for detail discussion of copyright issues.
Academic Computing

The UAMS Office of Academic Computing works in collaboration with the other Academic Affairs departments, the administrators and staff of the colleges and ancillary support services, as well as UAMS IT to plan, develop, and maintain services and facilities to support the use of information technology for education and academic information management.

Academic Computing provides support of computer labs for word processing, email, Internet access, etc. as well as computer-based instruction and exams; assistance with production and administration of computer-based exams; technical support of web-based distance learning platforms; services for preparing and scoring paper-based exams; support for course and faculty evaluations; and academic applications development and support.

The Academic Computing Advisory Committee, comprising associate deans of the colleges, directors of other service units related to the use of IT resources for education, serves to represent, at a high level, Academic Computing's constituency. The committee provides a forum for discussion of issues related to Academic Computing services and resources and development of recommendations on policies and priorities.

Academic Computing staff serve on a variety of UAMS committees dealing with planning and development of IT resources for academic purposes. The director and other staff also participate on advisory committees for other units and on committees related to the planning of campus-wide UAMS IT resources.
**Clinical Skills Center**

**Assessment**

The Clinical Skills Center has developed a collection of clinical cases that utilize standardized patients to assess medical, pharmacy, and nursing students, and health related professionals in taking

- a history
- performing a physical exam
- communicating with the patient
- determining a differential diagnosis
- developing a treatment plan.

A major area of interest is the patient and health professional relationship with detailed feedback on the adequacy of these skills. This approach to assessment can be tailored to match the needs of other professionals.

**Teaching**

Activities concentrate on the use of standardized patients and video technology to teach the following skills

- basic interviewing
- history examination
- physical taking
- clinical decision making

Skills are taught at a variety of levels--from first-year medical student to senior resident.

**Development**

We assist the various health professional colleges to develop programs utilizing the Clinical Skills Center and standardized patients.
Office of Academic Services

The Office of Academic Services coordinates support services to faculty, staff and students in the four UAMS colleges, graduate school and University Hospital. Support Services provided are related to classroom/laboratory teaching, distance learning and teleconferencing.

Academic Services is composed of six support divisions: Room Scheduling, AudioVisual Services, Laboratory Support, Telecommunications, Biomedical Building Management and Instrumentation Repair.

For information concerning the Office of Academic Services, please contact Dr. Kenneth Wagner via email at: wagnerkennethp@uams.edu

Our room schedule calendar is only a mouse click away.

Click Calendar now!
About OED

The mission of the Office of Educational Development is to improve teaching and learning at the University of Arkansas for Medical Sciences. To this end the office provides consultation to teachers and learners on the teaching and learning methodologies that have been shown to be effective and efficient. Faculty in the office work collaboratively with the faculty and administrative staff at UAMS to develop and evaluate new educational programs and the appropriate teaching and learning methods. In addition to providing consultation and collaborative development, the office manages several support areas that relate directly to the teaching and learning processes throughout the campus.

The Office of Educational Development is currently located in Shorey G/305, Jeff Banks JB330/332, and Jeff Banks Student Union JB2U06. The Shorey offices are across the hall from the Shorey elevators on the Ground Level, around the corner from the cafeteria. The Jeff Banks offices are on the 3rd Floor, one floor up from Student Activities room and Clinical Skills Center. The Jeff Banks Student Union Offices are across from the ballroom.

If you have questions or comments about this page please contact Anna Moses.

Office of Educational Development
University of Arkansas for Medical Sciences
4301 W. Markham St., #595
Little Rock, AR 72205
Welcome to the UAMS Library

The UAMS Library is open for anyone seeking health information or researching biomedical information. Although there are many free online resources, access to licensed resources is restricted to UAMS faculty, staff, and students. For additional information, please check out:

- Welcome to Visitors to the UAMS Library
- Health Information for the Public

Library News

- More News to Come

Library Special Feature:

**Psychiatry Online to PDA**

Psychiatry Online features ebooks, practice guidelines, journals, and self-assessment tools. The online subscription to Psychiatry Online allows you to download any section of the selected publications to a PDA. To use this feature, choose "My PsychiatryOnline" from the site and follow the instructions. Before installing content, you will need to sign-up for a personal account and download free Mobipocket reader software available from the website.

You can now download the entire DSM-IV-TR Classification to your PDA. Click here for the download link: [http://www.psychiatryonline.com/resourceTOC.aspx?resourceID=1](http://www.psychiatryonline.com/resourceTOC.aspx?resourceID=1).

Upcoming Event

**SCC/MLA 2005 Meeting**

The UAMS Library and other Arkansas, Health Sciences librarians are hosting the 2005 SCC/MLA Meeting October 22nd - 26th. For more information please visit the [2005 Meeting Web Site](http://www.library.uams.edu/).
Welcome to the UAMS Library Learning Resource Center (LRC)

The UAMS Library Learning Resource Center (LRC) is available to support the pursuit of education by UAMS students.

The LRC computers are available for the following purposes:

- Students using the LRC's educational programs or taking tests
- Students using Microsoft Office for educational use
- Students using the Internet or checking Email for educational purposes

LRC News and Announcements

- The LRC has added two online forms to make it easier than ever for instructors to make requests for testing in the LRC or reserve the Instructional room for classes and training. Check under "Links for Faculty."

Exam Sign Ups Available in the LRC

- None

Reviews Available in the LRC

- Microanatomy Quiz 1

  Begins: Wednesday, October 19, 2005
  Ends: Friday, October 21, 2005 at 5pm
  Review available on the LRC Computers
The Teaching Resource Center

The Teaching Resource Center is sponsored by the Teaching with Technology Committee (formerly the Self-Directed Learning Program (SDLP)). The Teaching with Technology Resource Center (Teaching Resource Center or TRC for short) is a place for UAMS faculty to use an assortment of up-to-date equipment and software with help and guidance of skilled LRC staff members. The Teaching and Technology Resource Center has evolved from the Faculty Development Room that was created in 1992 to honor of Dr. Horace Marvin.

The Teaching Resource Center consists of six different stations to meet the user’s needs. The most common functions are digital video editing, scanning and digital image editing, web development, and desktop publishing. However, there are several other programs available such as Impatica, Adobe Acrobat Professional, and Remark optical-mark-recognition software.

The Teaching Resource Center is located on the third floor of the UAMS Library and is available to UAMS faculty and their staff during the hours the Library is open. No appointments are necessary to use this room. Feel free to come by and let us show you what is available!

Video Editing Station

A Mac G4 with a dual processor able to handle digital videos up to two hours long. There is a Sony Digital Mini-recorder that allows standard VHS material to be converted to digital format for editing in iMovie. Movies can then be rendered into a Quicktime file to be burned to a CD, or set up with scenes and chapters and burned to a DVD. (Please note that we are installing a Superdrive that would allow for DVD burning in the near future.)

Multiple Slide-Scanning Station

A Mac G4 computer that is also capable of digital video editing. In addition, this computer is also connected to a Nikon Super Coolscan 8000 that is used to scan 35mm slides and photo negatives into digital format. This computer is equipped with software so the user can edit the scanned image if necessary. This computer also is equipped with a Superdrive that will allow CDs and DVDs to be burned.

“Catch All” Station

Here the user can quickly scan and edit images; Impaticize PowerPoint presentations for easy distribution or create multimedia PowerPoint presentations with video as well as narration using Impatica on Cue; create PDFs using Adobe Acrobat; develop tests or surveys using Perception; or create a webpage using Macromedia Dreamweaver. Soon this station will also be capable of capturing and editing slides being viewed on the microscope.

Desktop Publishing Station

Make snazzy documents for publication or distribution using Publishing software. The audience response system software CPS (Classroom Performance System) is also loaded here.

High Quality Scanning Station

A Mac G3 computer running OS9, an AGFA scanner, and a Polaroid single slide scanner. Here a user can scan images that require a higher quality for publication or archival purposes on the AGFA scanner and 35mm slides and photo negatives on the slide scanner. All scanned images can then be edited using image editing software. There is an external CD burner available as well.
Remark Station

This station is available for scanning paper surveys/questionnaires in order to manipulate data for reports. Using Textbridge Pro OMR (Optical Mark Recognition) software the user is able to achieve the goal of digitizing collected data into reports that can be manipulated.

Programs available in the Teaching Resource Center:

Adobe Creative Suite

- Acrobat Professional
- Photoshop
- InDesign

Adobe Photoshop versions 6 and 7
Impatica
Perception
iMovie
iDVD
iTunes
iPhoto
Microsoft Office

Macromedia

- Dreamweaver MX
- Fireworks MX

Last Updated: 01/07/2005
RESOURCES

Resources

- Social Work Department
- Research Your Health Topic
- Patient Stories
- Ask Dr. Lowe
- Parenting in Arkansas
- Health eKids
- ACHiever
- Video Library
- Center for Effective Parenting
- Immunizations
- Product Recalls

Arkansas Children's Hospital, 800 Marshall St., Little Rock, AR 72202-3591, (501) 364-1100 or TDD (501) 364-1184

ACH is a tobacco free campus.

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About ACH | Your Visit to ACH | Community Outreach Programs
Medical Services | Career Opportunities | Volunteer Opportunities
ACH Foundation | Press Room | Resources | Kids Only | Contact Us

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Welcome to the Clinical Computer Training Center

The Clinical Computer Training Center, Clinical Programs Education Department, is responsible for training UAMS staff and students on computer programs used at UAMS. We provide training in basic computer skills, SAP, Microsoft Office programs and hospital specific computer programs.

**IMPORTANT NOTICE**
Course Offerings to Change January 1st

If you need help on the Web Enrollment, please contact CCTC at 686-8966 or by email at cctc@uams.edu.

clinicalcomputertrainingcenter@uams.edu

Clinical Computer Training Center
Slot 526 - Computer
4301 West Markham Street
Little Rock, AR 72205 - 7198
Phone: (501) 686-8966
FAX: (501) 296-1579
E-Mail: cctc@uams.edu
Welcome to UAMS Creative Services

Order UAMS 2005 Graduation Memories Packages

View your photo and order portrait packages

Order Form (pdf format)

Introducing the New AP Stylebook Guidelines for UAMS

Creative Services wants to provide you, our client, with a letter-perfect job every time you visit us. To do that, our professional editor reviews every item that is designed or to be printed by Creative Services. We employ rigorous proofing and editing procedures to ensure that our products and printed items contain copy of the highest standards.

The Associated Press (AP) guidelines for grammar, punctuation and writing style have been adopted for the University of Arkansas for Medical Sciences (UAMS). The intent of using a common style for UAMS is to help achieve a consistency in writing across the entire university and hospital. Written communications will be clearer, and the UAMS brand will be protected.

The writing style of the Associated Press has been termed “the gold standard of news writing.” The Associated Press Stylebook provides a uniform presentation of the printed word which helps to clarify many aspects of writing, so that copy written anywhere is understandable everywhere.

If you have questions regarding the use of UAMS style, please contact Creative Services at (501) 686-5570.

Have you ever wondered...?

What is the correct spelling of "e-mail"?

Which is more acceptable? "Dr." or "DR"?

Is it ok to abbreviate addresses?

Should there be an apostrophe in master's degree?

Find the answers in the AP Stylebook Guidelines from Creative Services.

Your full service media production department, right here on campus.

We are dedicated to providing all members of the UAMS community with the best media related products available at a cost that is reasonable and in a location that is convenient and friendly. Services are available to all UAMS faculty, staff and students.

Helpful Web Features

- Free approved commonly used logos ready to download
- Free UAMS specific PowerPoint templates
- Free campus photographs available at PowerPoint resolution
- Order business cards and other stationery items on-line

Photos

New Classes

- We have redesigned our classes to make them a more efficient use of your time

Here is a partial listing of our services. Please call or e-mail us if you have any questions about this or any other media related matter.

Printing Services

- Course syllabi printing
- High speed Xerographic printing
- Offset color printing

Imaging Services

- Copy slides to CD-ROM
- Photographic restoration of historic images
- Medical/clinical photographers available 8-5
- Public relations and editorial photographers available 24/7
- Student and staff application, passport and immigration photos

Graphic Services

- Business card, Letterhead, Invitation, Envelope, notepad design and production
- Scientific posters up to 42"x 10' produced on-site

Television Services

- CD and DVD duplication
- Single or multiple camera event recording

Web Design Services

- Create web-based databases
- Produce multimedia projects
- Design, produce and maintain Web sites

Call 686-5570 for more information.
Fax: 686-8346 - Main Office
Everyone has problems at one time or another. Problems, like people, come in all sizes, types, intensities, and can come at any time. Problems sometimes start small, but can grow and spread to other areas of a person’s life, threatening a marriage, a career or both. Arkansas Employee Assistance Program (AEAP) provides counseling, information and referral (if indicated) for employees (including their spouses and dependents) who experience some form of personal distress. AEAP also has a management consultation component that addresses workplace wellness, consultation over workplace issues, and training.

- **Short-term, individual and family counseling**
- **Individual life skills training**
- **Life/Career coaching**
- **Wellness training**
- **Referral/resource assistance**

We can help with any of the following:

- **Stress management**
- **Life Balance**
- **Relationships**
- **Grief/bereavement**
- **Anger management**
- **Substance Abuse**
- **Personal/emotional concerns**
- **Work-related issues**
- **Eldercare**

**Organizational Services**

Organizations, like individuals, are challenged to stay healthy and productive. We believe people are the most important assets of a company; therefore, AEAP helps supervisors, managers and employees trouble shoot for potential problems, as well as, identify areas of potential growth. Employees are most productive when they enjoy their work environment; therefore, AEAP provides training and educational programs to improve the overall health and wellness of the organization.

- **Supervisor Consultation**
- **Strategic Planning**
- **Team Building**
- **Supervisors' Training**
- **Leadership Development**
Employee Health/Student Preventive Service

Student Health Services

EH/SPHS provides the following services at no cost to the student:

- Establishment and maintenance of an immunization record
- Tuberculosis skin test
- Measles/Mumps/Rubella (MMR) vaccine
- Tetanus/Diphtheria vaccine
- Hepatitis B vaccine series
- Post-vaccination Hepatitis B antibody testing
- Varicella vaccine series
- Influenza vaccine
- Health Risk Appraisal questionnaire
- Care of needlesticks and blood/body fluid exposures

Call 686-6565 if you have questions regarding our services.

EH/SPHS is located in the Family Medical Center at 6th and Elm streets, across from the Jones Eye Building. EH/SPHS has a separate entrance off of the parking lot. The clinic is open 8 AM to 4:30 PM, Monday through Friday. A satellite clinic is located on the 8th floor of the hospital. The satellite clinic is open 7:00 AM to 4:30 PM, Monday through Friday, and the second Saturday of every month from 7:00 to 11:00 AM. Both locations are closed on holidays.

An appointment is not necessary at either clinic.

FAMILY MEDICAL CENTER

The Family Medical Center (FMC) is conveniently located on the UAMS campus on the corner of 6th and Elm streets. The FMC offers medical care to students and their families who choose one of our Family Practice Physicians as their PCP. The FMC offers a full range of Primary Care including women's health, newborn, pediatric and adult care.

Appointments may be made by calling 686-6560.

When calling, please identify yourself as a UAMS student to receive preference in scheduling.

Students under the UAMS student insurance plan, QCA, are responsible for the co-payment at the time of check-in at the FMC. Students who have insurance other than QualChoice of Arkansas are responsible for any deductibles or copayments associated with their insurance.

Call 686-6565 and ask to speak with a manager if you have questions regarding service or billing.

Needlestick/Sharps Injuries and Blood/Body Fluid Exposure Policy

http://www.uams.edu/dfcm/student-employeehealth/
UAMS Fitness Center

Find Yourself
Start TODAY!

This fitness center is a commitment of UAMS to its employees and significant others to improve individual health and well-being by starting – and continuing – a regular exercise program.

A new YOU is not only possible, it can be reality. YOU can improve your health and well-being...right here at UAMS.

YOU are invited to stop by the 8th Floor of the College of Public Health building and check out the cutting-edge employee and student fitness facility.

While viewing the facility, be sure and pick up information on the UAMS wellness program, Stephens Spine Center pool, and Center on Aging fitness center. When you join the UAMS facility, you have access to ALL THREE at no additional cost.

The facility is open around the clock, 24 hours, seven days a week, with key card access for YOUR convenience.

Get Healthy UAMS "Find Yourself" Stories
Get Healthy UAMS "Find Yourself" Contest Winners
Anniversary Party Drawing Winners
Anniversary Celebration Sponsors
Ten Week Running Program
2005 Employee Wellness Screening Results
Susan G. Komen Race for the Cure

UAMS Fitness Center
4301 W. Markham St., #838 Little Rock, AR 72205
phone 501-526-2222  fax 501-526-7672
gethealthy@uams.edu

http://www.uams.edu/gethealthy/
**IT Tech Support Center**  
**686-8555**

The IT Tech Support Center is the first point of contact for computer-related questions or problems for all UAMS employees. The Tech Support Center offers the advantage of dialing one telephone number for assistance with any computer-related problem.

Our main goals are:

- To provide an immediate answer to questions or problems when possible.
- To assign it to the appropriate computing group when no resolution is immediately available.
- To track all calls administratively from initial call/assignment to complete resolution and make certain that every problem/complaint has been resolved.

**About Us...** find out about the consultants that are assisting you.

**HEAT 8.03 Project** - Improvements to help us better service our customers!
Welcome.

New!

A new bus shelter has been installed at the West end of Lot #5 at War Memorial Stadium.

Parking Application Status

(Click the link above to check the status of your parking application)

War Memorial Stadium Parking Lot Overflow Information

In the event the main lot at War Memorial Stadium is full, overflow parking is available on the West side of the stadium and on the West side of the Community Punishment Center. For a map of overflow area, click below.

Stadium Overflow Map

Online Customer Service Survey

http://www.uams.edu/parking/
ATTENTION

The UAMS Parking Operations Department has extended the hours of the East Deck visitor parking area. Consistent with the North Deck, a booth attendant will be on duty until **10:30 P.M.** Monday through Friday. If you have questions please contact the UAMS Parking Office at 686-5856.

Welcome to the Parking Operations Website at the UAMS Medical Center. It is our objective to provide parking and assistance to faculty, staff, students, patients, their families, and visitors to our campus. The series of photos above show construction phases of the East Parking Deck which opened September 1st, 1999.

This $9.2 million dollar expansion has added another 900 parking spots to the campus community. If you would like to apply for a spot on the East Deck, North Deck, or any of our other lots, please look under the Applications & Forms section listed above. Thanks for dropping by our website.

Thanks,

John Stidham
Director

PLEASE NOTE: Some of the forms found within this website were saved using the Adobe Acrobat program. In order to view them you must have the Acrobat Reader loaded on your computer. If you are unable to view a document, you will need to [Download](http://www.uams.edu/parking/) the reader. For more information about Adobe Acrobat 4.0, contact Adobe Systems.

Located in Little Rock, Arkansas

Maintained by [Parking Operations Webmaster](http://www.uams.edu/parking/)
This website was established on December 1st, 2000.
Welcome to the Department of Telecommunications at the UAMS Medical Center. We are here to provide reliable and timely service in the areas of telephones, cabling, and paging. Our organization takes pride in making sure our customers can count on us to keep their communication systems working.

Within this web site you should be able to research products, request service, get telephone and voice mail instructions and use one of many phone directories.

Send us any suggestions you have for items you would like added to this site. It is meant to be a tool to make your job easier.

Thanks,

Holly Naramore
Director

PLEASE NOTE: Some of the forms found within this website were saved using the Adobe Acrobat program. In order to view them you must have the Acrobat Reader loaded on your computer. If you are unable to view a document, you will need to Download the reader. For more information about Adobe Acrobat 4.0, contact Adobe Systems.
Professional Staff Office

The Professional Staff Office (PSO), located on the 2nd floor of the Child Study Center (CSC) at UAMS Medical Center, has five staff members and two primary functions.

Credentialing

The PSO is responsible for maintaining JCAHO and NCQA compliance while obtaining, verifying, and monitoring the credentialing and privileging information on all members of the hospital Medical Staff and Affiliated Health Professional Staff.

Enrollment

Once the applicant meets credentialing requirements and is granted privileges, the PSO will notify the hospital departments of the new practitioner. The PSO Provider Enrollment Coordinators complete all required documentation to enroll UAMS practitioners in Medicare, Arkansas Medicaid, Out of State Medicaid plans, and all other contracted health plans.

Seated: Mary Reed, Administrative Assistant, 686-8509
Cheryl Starnes, Director, Medical Staff Organization, 686-6328
Standing: Diana Sorce, Assistant Director, 526-4249
Sandra Hatley, Credentialing Coordinator, 686-8977
Shavada Harris, Provider Enrollment Coordinator, 603-1278
Vivian Phillips, Out of State Medicaid Provider Enrollment, 603-1528
E. UAMS Alumni, Fraternal and Professional Organizations

- UAMS Development and Alumni Affairs
- COM Caduceus Club
- Women's Faculty Development Caucus
- College of Nursing Alumni
- College of Pharmacy Alumni
- College of Health Related Professions Alumni
- Academic Senate

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10/13/2005