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The Florida State University College of Medicine
Compliance Program Policies and Procedures
for medical practices administered by the Florida Medical Practice Plan, Inc. (FMPP)

HIPAA Policies and Procedures
PRIVACY RULE

Business Associate Letter

Dear _________________________,
(Business Associate)

As you are aware, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) encompasses significant instructions and requirements regarding the control and care of protected health information (PHI). The prevailing sections of the act are commonly known as the HIPAA “Privacy Rule.” The rule mandates that numerous precautions be taken and safeguards be put in place to protect our patients’ protected health information from unwanted disclosure and possible unauthorized use.

As a result, we are sending you our “Business Associate Privacy Agreement.” This agreement protects our patients, our practice, and you as a business associate with whom we might have occasion and necessity to share pertinent protected health information in order to effect proper treatment.

Our practice requires that all those with whom we do business comply with the law and always use their best efforts to serve our patients. Together, we can assure our patients that their treatment is superior and their confidence is well placed.

To this end, please sign and return the enclosed agreement.

Sincerely,

HPAPF.001(1)
Origination date: 4/29/2015
The Florida State University College of Medicine Compliance Program Policies and Procedures
for medical practices administered by the Florida Medical Practice Plan, Inc. (FMPP)

HIPAA Policies and Procedures
PRIVACY RULE

Notice of Privacy Practices
Florida Medical Practice Plan, Inc.
Clinic address and phone

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment:
We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment:
Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations:
We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you.

HPAPF.002
Origination date: 4/29/2015
upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law. You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician’s practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your protected health information and by law we must comply when the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. By law, you may not request that we restrict the disclosure of your PHI for treatment purposes.

You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of all disclosures except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of this request.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. We will not retaliate against you for filing a complaint.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Please sign the accompanying “Acknowledgment” form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

HPAPF.002
Origination date: 4/29/2015
The Florida State University College of Medicine
Compliance Program Policies and Procedures
for medical practices administered by the Florida Medical Practice Plan, Inc. (FMPP)

HIPAA Policies and Procedures
PRIVACY RULE

Notice of Privacy Practices Acknowledgment
(Practice Name)

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

Patient Name or Legal Guardian (print) __________________________ Date __________________________

Signature __________________________

Office Use Only

We have made the following attempt to obtain the patient’s signature acknowledging receipt of the Notice of Privacy Practices:

Date: _______________ Attempt: ______________________________________________

Staff Name: _______________________________________

HPAPF.002(4)
Origination date: 4/29/2015
HIPAA Policies and Procedures
PRIVACY RULE

Request to Inspect or Copy Patient Information

(Name of Practice)

Patient Name: __________________________________________

Date of Birth: __________________________

Patient Address:

Street

City, State Zip

Requested patient information
Please describe the information that you would like us to provide a copy of:

________________________________________________________________________

________________________________________________________________________

We will review your request to determine if the information can be made available to you. In some cases, we may be legally prohibited from disclosing certain information. For further details please refer to our Notice of Privacy Practice.

We will complete our review of your request within the next 20 days and contact you either by phone or writing to arrange for you to inspect or pick up a copy of your records. An administrative fee of $________ will be charged for copying the requested material.

If we are unable to accommodate or deny your request, we will notify you in writing.

Patient Signature or Personal Representative Date

HPAPF.002(9a)
Origination date: 4/29/2015
Request was received by: __________________________ Date: ______________________
(Name and title of staff receiving / processing this request)

☐ We hereby accept this request. __________________________

☐ We hereby deny this request. __________________________

Practice Representative (Type/Print) __________________________

Practice Representative Signature __________________________

Date __________________________

HPAPF.002(9a)
Origination date: 4/29/2015
The Florida State University College of Medicine Compliance Program Policies and Procedures for medical practices administered by the Florida Medical Practice Plan, Inc. (FMPP)

HIPAA Policies and Procedures
PRIVACY RULE

Response to Patient Request to Inspect or Copy Patient Information

(Name of Practice)

Patient Name: __________________________________________

Date of Birth: ________________________________

Patient Address:

____________________________________________________

Street

City, State Zip

Date of Patient Request: ____________________________

We have reviewed your request to inspect or copy patient information on _____ / ____ / ____.
(See attached copy of the original request).

☐ Your request has been accepted.

Please contact our office to arrange for a specific date and time to retrieve copies of this information.

☐ We regret to inform you that your request has been denied for the following reasons:

____________________________________________________

____________________________________________________

If you do not agree with our denial you may submit a complaint to the Secretary of Health and Human Services and/or a complaint to our clinic at the following address:

Attention: <Name of Compliance Officer>
Street Address
City, State, Zip Code

Request to Appeal the Denial
HPAPF.002(9b)
Origination date: 4/29/2015
☐ Check the box if you would like to appeal this denial. In addition to submitting a compliant, you also have the right to request a second review. If you wish to do so, please sign below and return this form to our clinic at the address listed above. We will have another physician of our choosing conduct an independent review and notify you of the results.

Patient Signature or Personal Representative __________________________ Date ______________

Office Use Only

Request was received by: __________________________ Date: __________________________
(Name and title of staff receiving / processing this request)
The Florida State University College of Medicine Compliance Program Policies and Procedures
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HIPAA Policies and Procedures
PRIVACY RULE

Request to Amend Patient Records
(Name of Practice)

Patient Name: _______________________________________________________

Date of Birth: __________________________

Patient Address: ______________________________________________________

Street

City, State Zip

I request that the following medical record information be amended (attached a separate document if needed):

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

Reason for the requested change:

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

I understand that you will review my request to amend records and provide a written determination within 60 days. I also understand that Federal Regulations may not allow information to be amended under certain circumstances specified by HIPPA Privacy Rules 45 CFR 164.526. If the request is denied, I understand that I may submit a written statement explaining my disagreement with the decision, which statement will be included in my medical records, along with any response from the practice.

HPAPF.002(11a)
Origination date: 4/29/2015
If the amendment is approved, in whole or in part, I understand the practice will make the appropriate amendment to my records and also is required to make reasonable efforts to inform and provide the amendment within a reasonable time to other entities or practices who received the PHI.

Patient Signature or Personal Representative

Date

Office Use Only

☐ We hereby accept this request.

☐ We hereby deny this request.

Practice Representative (Type/Print)

Practice Representative Signature

Date

HPAPF.002(11a)
Origination date: 4/29/2015
The Florida State University College of Medicine
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HIPAA Policies and Procedures
PRIVACY RULE

Response to Request to Amend Patient Records

(Name of Practice)

Patient Name: ____________________________________________

Date of Birth: ________________________________

Patient Address:

______________________________________________

Street

City, State Zip

Date of Patient Request: ____________________________

We have reviewed your request to amend patient records on _____ / _____ / _______.
(See attached copy of the original request).

☐ Your request has been accepted.

☐ A portion of your request has been accepted. The following information will be amended pursuant
to your request.

We will identify the records in your designated record set that are affected by this amendment and
append or otherwise provide a link to the location of the amendment. We will make a reasonable effort to
inform and provide the amendment within a reasonable time to any persons identified by you that need
the amendment and any business associates (that we know of) that may have information affected by this
amendment

☐ We regret to inform you that your request has been denied for the following reasons:

______________________________________________

HPAPF.002(11b)
Origination date: 4/29/2015
If you disagree with this decision, you may submit a written statement of disagreement. You may request to have your written disagreement included as part of your designated medical record. We will provide this information to any entity to whom the affected information is disclosed in the future. If you do not wish to submit a statement of disagreement you may request that we include your request for amendment and the denial thereof with any future disclosures.

If you wish, you may also submit a complaint to the Secretary of Health and Human Services and/or a complaint to our clinic at the following address:

Attention: <Name of Compliance Officer>
Street Address
City, State, Zip Code

__________________________________________ Date: ________________
Signature of Compliance Officer

HPAPF.002(11b)
Origination date: 4/29/2015
HIPAA Policies and Procedures
PRIVACY RULE

Request for Accounting of Disclosure of PHI

(Name of Practice)

Patient Name: __________________________________________

Date of Birth: ______________________

Address:

Street ______________________ City, State Zip _______

I hereby request for an accounting of disclosures for the following dates:

From: ______________________ To: ______________________

(must be after 4/14/2003)

I understand that the practice is not required to provide an accounting of all disclosures which include:

1. To carry out treatment, payment and health care operations as providers
2. Disclosures pursuant to an authorization
3. For reporting neglect or abuse
4. For national security purposes
5. PHI that is part of a limited data set for research
6. Disclosures that occurred prior to April 14, 2003

Patient Signature or Personal Representative ______________________ Date ________________

Signature of Practice Representative ______________________ Date ________________

HPAPF.002(12)
Origination date: 4/29/2015
The Florida State University College of Medicine
Compliance Program Policies and Procedures
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HIPAA Policies and Procedures
PRIVACY RULE

Request for Restriction of Use and Disclosure of PHI

(Name of Practice)

Patient Name: ____________________________________________

Date of Birth: ______________________

Patient Address:

__________________________________________

Street

City, State Zip

Requested Restriction
What PHI would you like restricted:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Please describe you would like the PHI to be restricted:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Note: The practice is not required to agree to your request. Please see our notice of privacy practices for more information regarding such requests. In addition, our practice may terminate this agreement to restriction based on the following:

• You agree to or request a termination in writing

HPAPF.002(13a)
Origination date: 4/29/2015
• You orally agree to the termination and the oral agreement is documented, or
• Our practice informs you that we are terminating the agreement. We will only be able to use or disclose protected health information that is created or received after the restriction agreement is terminated.

______________________________  ____________________________
Patient Signature or Personal Representative  Date

Office Use Only

☐ We hereby accept the above restriction of PHI.
   (Type/Print)  Compliance Officers Name

☐ We hereby deny this request for restriction of PHI.

Compliance Officer Signature

__________________________
Date

HPAPF.002(13a)
Origination date: 4/29/2015
The Florida State University College of Medicine
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HIPAA Policies and Procedures
PRIVACY RULE

Response to Request for Restrictions of Use and Disclosure of PHI

(Name of Practice)

Patient Name: ____________________________________________

Date of Birth: ____________________________

Patient Address:

Street ____________________________________________
City, State Zip ______________________________________

Date of Patient Request: ____________________________

We have reviewed your request for restrictions on the use and disclosure of PHI on ______ ____________
(See attached copy of the original request).

☐ Your request has been accepted.

We will make the necessary assurances to accommodate your request.

☐ We regret to inform you that your request has been denied for the following reasons:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

HPAPF.002(13b)
Origination date: 4/29/2015
If you do not agree with our denial you may submit a complaint to the Secretary of Health and Human Services and/or a complaint to our clinic at the following address:

Attention: <Name of Compliance Officer>
Street Address
City, State, Zip Code

Sincerely,

Privacy Officer

HPAPF.002(13b)
Origination date: 4/29/2015
The Florida State University College of Medicine
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for medical practices administered by the Florida Medical Practice Plan, Inc. (FMPP)

HIPAA Policies and Procedures
PRIVACY RULE

Request for Confidential Communication of PHI
(Name of Practice)

Name of Patient: ________________________________

Patient Date of Birth: _______________ Date of Request: _______________

____________________________________________________________________

Please indicate how you would like the practice to communicate with the patient:
(e.g. alternate address, alternate phone, email)

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

The following communications should be provided via the method described above:

____________________________________________________________________

If this request limits the practice’s ability to collect payment for services rendered, I agree to be
responsible for paying the bill in full. If I fail to pay the bill within 30 days, I agree to allow the practice to
contact me at any other known addresses or phone numbers for purposes of seeking payment.

Patient Signature or Personal Representative __________________________ Date ______________

Office Use Only

Request was received by: ___________________________ Date: ______________________
(Name and title of staff receiving / processing this request)

HPAPF.002(14a)
Origination date: 4/29/2015
☐ We hereby accept this request.

☐ We hereby deny this request.

Practice Representative (Type/Print)

Practice Representative Signature

Date ______________________

HPAPF.002(14a)
Origination date: 4/29/2015
The Florida State University College of Medicine
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HIPAA Policies and Procedures
PRIVACY RULE

Response to Request for Confidential Communication

(Name of Practice)

Patient Name: ______________________________________
Date of Birth: ________________________________
Patient Address: ______________________________________

Street                                      City, State Zip

Date of Patient Request: ________________________________

We have reviewed your request for confidential communication on _____ / _____ / _____.
(See attached copy of the original request).

☐ Your request has been accepted.
We will make the necessary assurances to accommodate your request.

☐ We regret to inform you that your request has been denied for the following reasons:

__________________________________________________________

__________________________________________________________

__________________________________________________________

__________________________________________________________

HPAPF.002(14b)
Origination date: 4/29/2015
If you do not agree with our denial you may submit a complaint to the Secretary of Health and Human Services and/or a complaint to our clinic at the following address:

Attention: <Name of Compliance Officer>
Street Address
City, State, Zip Code

Sincerely,

Privacy Officer
The Florida State University College of Medicine
Compliance Program Policies and Procedures
for medical practices administered by the Florida Medical Practice Plan, Inc. (FMPP)

HIPAA Policies and Procedures
PRIVACY RULE

Review of Denial for Request to Inspect Protected Health Information

(Name of Practice)

This notice is to inform you that per your request, we have conducted an independent review of your denied request to inspect or copy protected health information.

Date of initial request: _____/_____/_____.

Based upon our second review:

☐ Your request has been accepted.

Please contact our office to arrange for a specific date and time to retrieve copies of this information. You may also have us arrange to make copies and mail them to you. Please note, we will charge a small administrative fee for pulling the records and making copies; in addition to the cost of any postage for delivery.

☐ We regret to inform you that your request has been denied:

__________________________________________________________________________
Information Requested
Reason for Denial

__________________________________________________________________________
Information Requested
Reason for Denial

__________________________________________________________________________
Information Requested
Reason for Denial

HPAPF.002(15)
Origination date: 4/29/2015
Within the limitations of the law, we will make every effort to accommodate your request.

We will complete our review of your request and either arrange for you to inspect or copy your records within 30 days of your request, or provide you with a written explanation of any restriction on the information that we can provide you.

If we deny your request, in whole or in part, you may request that we review that decision.

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The Florida State University College of Medicine
Compliance Program Policies and Procedures
for medical practices administered by the Florida Medical Practice Plan, Inc. (FMPP)

HIPAA Policies and Procedures
PRIVACY RULE
Fees Related to Copying of Medical Records

Florida Medical Practice Plan, Inc. charges for reproduction of medical records according to Florida Administrative Code, Rule 64B8-10.003, as outlined below:

- No more than $1.00 per page for the first 25 pages of written material
- $.25 for each additional page
- Actual cost of reproducing non-written records such as x-rays
- "Recognizing that patient access to medical records is important and necessary to assure continuity of patient care, the Board of Medicine urges physicians to provide their patients a copy of their medical records, upon request, without cost, especially when the patient is economically disadvantaged."

Unless otherwise requested, records will be sent by US mail. Records needed for medical emergencies will be faxed directly to a physician or medical facility.

For questions regarding requests for medical record copies, please contact Connie Donohoe, Florida Medical Practice Plan, Inc. at connie.donohoe@med.fsu.edu or 850-645-6867.

Date _______________  Patient Name __________________________

Number of Pages Provided __________________________

Number of pages at $1 each __________________________ (no more than 25 pages)

Number of pages at $0.25 each __________________________

Total Received __________________________

HPAPF.028(4)
Origination date: 9/3/2015
## HIPAA Policies and Procedures

### SECURITY RULE

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<td>HPASF.015</td>
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<tr>
<td>Business Associate Checklist</td>
<td>HPASF.021(a)</td>
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<tr>
<td>Business Associate Agreement</td>
<td>HPASF.021(b)</td>
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<td>Emergency Access Procedures</td>
<td>HPASF.022</td>
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<tr>
<td>Equipment and Information Technology Inventory</td>
<td>HPASF.023</td>
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<tr>
<td>Visitor Log</td>
<td>HPASF.024</td>
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<td>Facility Maintenance Record</td>
<td>HPASF.025</td>
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<td>Employee IT Access List</td>
<td>HPASF.032</td>
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<tr>
<td>Identify Verification</td>
<td>HPASF.038</td>
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</tbody>
</table>
HIPAA Policies and Procedures
SECURITY RULE

IT System Activity Review Log
This document is to be used to conduct the Information System Activity Review required by HIPAA Security Rule (164.308.a).

<table>
<thead>
<tr>
<th>List System Activity Reviewed (e.g. audit log, access reports)</th>
<th>Reviewed (date)</th>
<th>Reviewed (by)</th>
<th>Issue(s) Identified (yes/no)</th>
<th>If yes, Describe Issue Identified</th>
<th>Action Plan (to mitigate the issue / risk)</th>
<th>Resolved (date)</th>
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HPASF.003
Origination date: 4/29/2015
The Florida State University College of Medicine
Compliance Program Policies and Procedures
for medical practices administered by the Florida Medical Practice Plan, Inc. (FMPP)

HIPAA Policies and Procedures
SECURITY RULE

Employee Termination Checklist

(Practice Name)

Employee Name ____________________________  Termination Date ____________________________

☐ All building keys or badges have been returned to Security Officer.
☐ Email access has been eliminated. Account has been forwarded to Security Officer.
☐ Voicemail access has been eliminated. Account has been forwarded to appropriate staff.
☐ Intranet / System passwords have been terminated
☐ Employee IT Access List has been updated.
☐ Employee directory has been updated (website, phone lists etc.)
☐ Personal Computer / Laptop has been returned
☐ PDA’s, pager, cell phone has been returned
☐ Unused vacation / sick time credited for last pay check
☐ Termination letter outlining benefits status and end dates has been provided
☐ Confidentiality agreements that were signed have been reviewed with employee
☐ Final timesheet and expenses submitted
☐ Exit interview conducted

__________________________________________  Date: ____________________________
Administrator / HR Signature

HPASF.007
Origination date: 4/29/2015
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Compliance Program Policies and Procedures
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HIPAA Policies and Procedures
SECURITY RULE
IT Access Change Request Form
(Practice Name)

Employee Name

Date of Request

Current Employee Access Rights:
(List all systems, software, hardware the employee currently has access rights)

1.

2.

3.

4.

Change Requested:

Reason for the Change:

*Changes are appropriate as it relates to the job duties of the employee
*Update the Employee IT Access List

Approval:

Administrator Signature

Date: ______________

Security Officer Signature

Date: ______________

HPASF.009
Origination date: 4/29/2015
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Compliance Program Policies and Procedures
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HIPAA Policies and Procedures
SECURITY RULE

BREACH NOTIFICATION CHECKLIST

Timing
____ Discovery date recorded: ______________________
____ Deadline for notifications (60 days post-discovery): ______________________
____ Law enforcement determination of notification delay (based on hindering criminal investigation or causing damage to national security); if so:
  ____ Documentation of determination
  ____ Extended deadline for notifications: ______________

Identification of Breached Data
____ Includes PHI: Y/N
____ PHI is encrypted/unencrypted/both/undetermined
____ Affected individuals have been identified

Determination of Urgency
____ Decision re: danger of imminent misuse of PHI/PHR data (If so, document decision and escalate notification procedures.)

Notice
____ Individual notice prepared, containing:
  ____ Brief description of what happened, date of breach, and date of discovery
  ____ Description of types of unsecured PHI involved (e.g., name, SSN, DOB, home address, account number, etc.)
  ____ Steps individuals should take for protection
  ____ Brief description of what we are doing to investigate the breach, mitigate losses, and protect against further breaches
  ____ Contact information for queries and to learn additional information, including toll-free phone number, e-mail address, Web site, and/or mailing address
____ Notice to Secretary HHS
____ If 500 or more individuals affected, immediate notice given
____ If < 500 individuals affected, log entry made (to be submitted at end of year)

HPASF.014
Origination date: 4/29/2015
Notice to Media

If 500 or more individuals affected

Contact Information and Mailings

Notification mailed to current address of individuals (or next of kin) as available

Insufficient or out-of-date information for 10 or more individuals? If so:

Public notice posted on our Web site

Public notice in major print or broadcast media in affected geographic regions

HPASF.014
Origination date: 4/29/2015
The Florida State University College of Medicine
Compliance Program Policies and Procedures
for medical practices administered by the Florida Medical Practice Plan, Inc. (FMPP)

HIPAA Policies and Procedures
SECURITY RULE

HIPAA Security Incident Report
(Name of Practice)

Name of person reporting the suspected or known security incident          Date

Explain the suspected or known security incident

Location of suspected or known security incident

Name of HIPAA Security Officer

Was the HIPAA Security Officer contacted immediately?
By phone, in person, other

What was done to resolve this issue?

HPASF.014(a)
Origination date: 4/29/2015
What will we do to avoid this situation in the future?

Security Officer Signature

Date

HPASF.014(a)
Origination date: 4/29/2015
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HIPAA Policies and Procedures
SECURITY RULE

Breach Notification Letter

To an individual
(Practice Name)
(Practice Address)
(Practice Phone Number)

Date ________________________________

Dear (Name)________________________________:

We are writing to you because of a recent security incident at our practice in which unsecured data was breached.

Following is a description of information regarding the breach.

Name of patient: ____________________________________________

Date of breach: ________________________________

Date of discovery of breach: ________________________________

Information breached: (check all that apply)

___ Name __ Address

___ Phone Number __ Email address

___ Social Security Number __ Driver’s License Number

___ State ID Number __ Financial Data

___ Protected health information (PHI)

HPASF.014(b)
Origination date: 4/29/2015
Other information breached: 

How the breach occurred: 

These measure are being undertaken to address the incident: 

We recommend that you regularly review the explanation of benefits statement that you receive from your health insurance plan. If you see any service that you believe you did not receive, please contact them.

You may want to order copies of your credit reports and check for any medical bills or other charges that you do not recognize. If you find anything suspicious, call the credit reporting agency at the phone number on the report. Those agencies are:

- Equifax (888)766-0008 or www.fraudalert.equifax.com
- Experian (888) 397-3742 or www.experian.com
- TransUnion (800) 680-7289 or www.transunion.com

We regret that this incident occurred and want to assure you that we are reviewing and revising our procedures and practices to minimize the risk of recurrence.

Should you need any further information about this incident, please contact me.

Sincerely,

(Name of designated official)  
(Phone Number)  
(email)  

HPASF.014(b)  
Origination date: 4/29/2015
The Florida State University College of Medicine Compliance Program Policies and Procedures for medical practices administered by the Florida Medical Practice Plan, Inc. (FMPP)

HIPAA Policies and Procedures
SECURITY RULE

Breach Notification Letter

To the Media

(Practice Name)
(Practice Address)
(Practice Phone Number)

Date____________________________

To: (Name of Media Organization):

To Whom It May Concern:

Pursuant to the federal HIPAA HITECH law, we are writing to you because of a recent security incident at our practice in which unsecured data that involved 500 or more of our patients was breached.

Following is information regarding the breach.

Date of breach: ________________________________________________________________

Date of discovery of breach: ______________________________________________________

Information breached: (check all that apply)

____ Names  ____ Addresses
____ Phone Numbers  ____ Email addresses
____ Social Security Numbers  ____ Driver's License Numbers
____ State ID Numbers
HPASF.014(c)
Origination date: 4/29/2015

____ Financial Data
____ Protected health information (PHI)

Other type of information breached (not specific information):

_________________________________________________________________________

_________________________________________________________________________

How the breach occurred: ______________________________________________________

_________________________________________________________________________

These measures are being undertaken to address the incident: __________________________

_________________________________________________________________________

If you should need any further information regarding this incident, please contact me.

(Name of designated official)

(Phone Number)

(email)
The Florida State University College of Medicine
Compliance Program Policies and Procedures
for medical practices administered by the Florida Medical Practice Plan, Inc. (FMPP)

HIPAA Policies and Procedures
SECURITY RULE

Breach Notification Letter

To the Department of Health and Human Services

(Practice Name)
(Practice Address)
(Practice Phone Number)

U.S. Department of Health and Human Services
200 Independence Ave. S.W.
Washington DC 20201

Date ________________________________

Pursuant to the federal HIPAA HITECH law, we are writing to you because of a recent security
incident at our practice in which unsecured data that involved 500 or more of our patients was
breached.

Following is information regarding the breach.

Date of breach: ________________________________

Date of discovery of breach: ________________________________

Information breached: (check all that apply)

____ Names
____ Addresses
____ Phone Numbers
____ Email addresses
____ Social Security Numbers
____ Driver’s License Numbers

HPASF.014(d)
Origination date: 4/29/2015
____ State ID Numbers
____ Financial Data
____ Protected health information (PHI)

Other type of information breached (not specific information):

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

How the breach occurred:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

These measures are being undertaken to address the incident:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

If you should need any further information regarding this incident, please contact me.

(Name of designated official)

(Address)

(Phone Number)

(email address)

HPASF.014(d)
Origination date: 4/29/2015
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HIPAA Policies and Procedures
SECURITY RULE

Annual HIPAA Incident Summary Log

The HIPAA Incident Summary Log should be used to document all HIPAA violations/breaches. This log should be filled out in conjunction with the HIPAA Incident and Resolution Form. Information from the form will be used to provide the annual report to HHS for any breaches involving 500 individuals or less.

Name of Practice: ___________________________ Reporting Year: _______________

<table>
<thead>
<tr>
<th>No.</th>
<th>Description of Incident/Violation</th>
<th>Date of Discovery</th>
<th>Steps taken to Resolve</th>
<th>Disciplinary Action Taken</th>
<th>Resolved (date)</th>
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Compliance Program Policies and Procedures
for medical practices administered by the Florida Medical Practice Plan, Inc. (FMPP)

HIPAA Policies and Procedures
SECURITY RULE

Daily Data Back-up List

The following data is backed up daily by a remote back-up system:

1. 
2. 
3. 
4. 
5. 
6. 
7. 
8. 

Copies of back-up media are security stored on (Tape, Disk) located in ____________________.

The Security Officer is responsible for verifying all back-up procedures and conducting a regular audit of back-up media to ensure the integrity and accuracy of data.
The Florida State University College of Medicine
Compliance Program Policies and Procedures
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HIPAA Policies and Procedures
SECURITY RULE

Business Associate Checklist
A Business Associate is any entity or person who participates or performs a function or activity involving the use or disclosure of a patient’s identifiable health information, including (but not limited to) claims processing or administration, data analysis, billing, practice management, consulting, legal, accounting, utilization review, quality assurance or other related activities.
The Business Associate checklist should be used to identify and track all business associates related to your practice and ensure each business associate has signed and returned a Business Associate Agreement as required by HIPAA Regulations:

<table>
<thead>
<tr>
<th>Name of Business Associate</th>
<th>Contact Name</th>
<th>Address</th>
<th>Phone</th>
<th>Signed BAA</th>
<th>Date Received</th>
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HPASF.021(a)
Origination date: 4/29/2015
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HIPAA Policies and Procedures
SECURITY RULE
BUSINESS ASSOCIATE AGREEMENT

This BUSINESS ASSOCIATE AGREEMENT (the "Agreement"), is entered into and made this __________ day of ____________________ , 20 ___ between

____________________________________ (Name of Business Associate) ______________________________ ("Business Associate")

with the address of:

and THE FLORIDA STATE UNIVERSITY BOARD OF TRUSTEES, for and on behalf of the
Florida State University and its College of Medicine, ("Covered Entity"),
with the address of 1115 West Call Street, Tallahassee, Florida 32306-4300,

for the purpose of:

____________________________________ (Brief description of the service/product being provided by the Business Associate)

WITNESSETH

WHEREAS, Covered Entity is a health care provider and a "covered entity" as defined in the Health Insurance Portability and Accountability Act of 1996 and related regulations, as amended from time to time ("HIPAA"); and

WHEREAS, Business Associate is a "business associate" as defined in HIPAA; and

WHEREAS, Covered Entity wishes to commence or continue a business relationship with Business Associate that shall be/has been memorialized in a separate agreement (the "Underlying Agreement"), and the nature of the Underlying Agreement may involve the exchange of Protected Health Information ("PHI") as that term is defined in HIPAA; and

WHEREAS, the HIPAA Privacy Standards, as amended from time to time (the "Privacy Rule"), require Covered Entity to obtain and document satisfactory assurances from the Business Associate that the Business Associate shall appropriately safeguard PHI through a written contract; and

WHEREAS, the HIPAA Security Standards, as amended from time to time (the "Security Rule"), govern the security of PHI obtained, created or maintained electronically by covered entities and business associates as defined in HIPAA; and

WHEREAS, the Health Information Technology for Economic and Clinical Health ("HITECH") Act, found in Titles XIII and XIV of the American Recovery and Reinvestment Act of 2009, modifies certain provisions of HIPAA relating to the privacy and security of PHI; and

WHEREAS, the parties acknowledge that, in the event of a violation of HIPAA or the HITECH Act by Business Associate, Business Associate may be subject to the same civil and criminal penalties as Covered Entity would be for such violation by Covered Entity; and

HPASF.021(b)
Origination date: 4/29/2015
WHEREAS, the parties desire to enter into this Agreement for the purpose of ensuring compliance with the requirements of HIPAA, its implementing regulations, the HITECH Act and Florida law.

NOW THEREFORE, in consideration of their mutual promises made herein, and for other good and valuable consideration, receipt of which is hereby acknowledged by each party, the Parties, intending to be legally bound, herein agree as follows:

1. **Definitions for Use in This Agreement.** Terms used but not otherwise defined in this Agreement shall have the same meaning ascribed to those terms in HIPAA, the HITECH Act, and any current and future regulations promulgated under HIPAA or the HITECH Act.

2. **Obligations and Activities of Business Associate.**
   
   a. Upon request by Covered Entity, Business Associate shall provide to Covered Entity evidence of the performance of an information security assessment as required by the HIPAA Security Rule, which evidence shall be satisfactory to Covered Entity.

   b. Upon request by Covered Entity, Business Associate shall provide to Covered Entity a copy of its written policies and procedures relating to the security of PHI and the name of the person responsible for implementing the HIPAA Security Rule and this Agreement on behalf of Business Associate.

   c. Except as otherwise limited in this Agreement, Business Associate may use or disclose PHI to perform functions, activities or services for, or on behalf of, Covered Entity as specified in the Underlying Agreement provided that such use or disclosure would not violate the Privacy Rule. Business Associate agrees to not use or disclose PHI other than as permitted or required by this Agreement or as Required by Law, as that term is defined in HIPAA, the HITECH Act and/or applicable regulations.

   d. Business Associate agrees to use appropriate safeguards to prevent use or disclosure of PHI other than as provided for by this Agreement.

   e. Business Associate shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of PHI that it creates, receives, maintains or transmits on behalf of the Covered Entity.

   f. Business Associate agrees to mitigate, to the extent practicable, any harmful effect known to Business Associate of its use or disclosure of PHI in violation of the requirements of this Agreement and/or the Privacy Rule or Security Rule.

   g. Business Associate agrees to report in writing to Covered Entity any use or disclosure of PHI not provided for by this Agreement within ten (10) calendar days after becoming aware of such use or disclosure.

   h. Business Associate shall report to Covered Entity within ten (10) calendar days after becoming aware of any "security incident," as that term is defined in the HIPAA Security Rule. In its report to Covered Entity, the Business Associate shall identify: the date of the security incident, the scope of the security incident, the Business Associate's response to the security incident and the identification of the party responsible for causing the security incident, if known.

   i. Business Associate shall report in writing to Covered Entity any breach involving PHI, as the term "breach" is defined in the HITECH Act, by completing the Breach Notification form attached hereto as Exhibit "A" and by reference made a part hereof. Business Associate shall provide said notification to Covered Entity of any such breach within ten (10) calendar days after such breach.

   j. Business Associate agrees to ensure that any agent, including a subcontractor, to whom it provides PHI received from, created by, or received by Business Associate on behalf of Covered
Entity agrees to the same restrictions and conditions that apply through this Agreement to Business Associate with respect to such information.

k. Within ten (10) business days after a written request from Covered Entity, Business Associate agrees to provide access to PHI in a Designated Record Set (“DRS”), as that term is defined in HIPAA, to Covered Entity or, as directed by Covered Entity, to an Individual, as that term is defined in HIPAA, in order to meet the requirements under 45 CFR §164.524. In the event any Individual requests access to PHI directly from Business Associate, Business Associate shall forward written notice of such request to Covered Entity within ten business (10) days after such request. Any denials of access to the PHI requested shall be the responsibility of Covered Entity.

l. Business Associate agrees to make any amendment(s) to PHI in a DRS that the Covered Entity directs or agrees to pursuant to 45 CFR §164.526 at the written request of Covered Entity or an Individual, within twenty (20) business days of the written request.

m. Business Associate agrees to make internal practices, books, and records, including policies and procedures and PHI, relating to the use and disclosure of PHI received from, or created or received by Business Associate on behalf of Covered Entity, available to the Covered Entity and to the Secretary, within fifteen (15) business days after notice of the Secretary’s request or in the time and manner designated by the Secretary, for purposes of the Secretary determining Covered Entity’s compliance with the Privacy Rule and the Security Rule.

n. Business Associate agrees to document disclosures of PHI and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR §164.528.

o. Business Associate agrees to provide to Covered Entity, or to an Individual at the request of the Covered Entity, or to the Individual if the request is made directly to the Business Associate by the Individual within fifteen (15) business days of written notice from Covered Entity to Business Associate, information collected in accordance with Section 2.0. of this Agreement, to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures of in accordance with 45 CFR §164.528.

p. Business Associate shall comply with the privacy, security and security breach notification provisions applicable to a business associate under the HITECH Act and any regulations promulgated thereunder, including but not limited to compliance with each of the Standards and Implementation Specifications of 45 CFR §§164.308 (Administrative Safeguards), 164.310 (Physical Safeguards), 164.312 (Technical Safeguards), 164.316 (Policies and Procedures and Documentation Requirements), and 164.410 (Notification by a Business Associate).

3. Permitted Uses and Disclosures by Business Associate - General Use and Disclosure Provisions. Except as otherwise limited in this Agreement, Business Associate may use or disclose PHI to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in the Agreement, provided that such use or disclosure would not violate the Privacy Rule if done by Covered Entity or the minimum necessary policies and procedures of Covered Entity.

4. Permitted Uses and Disclosures by Business Associate - Specific Use and Disclosure Provisions.

   a. Except as otherwise limited in this Agreement, Business Associate may use PHI for the proper management and administration of Business Associate or to carry out Business Associate’s legal responsibilities.

   b. Except as otherwise limited in this Agreement, Business Associate may disclose PHI for the proper management and administration of Business Associate, provided that disclosures are Required By Law or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential 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 Business Associate of any instances of which it is aware in which the confidentiality of the

HPASF.021(b)
Origination date: 4/29/2015
information has been breached.

c. Except as otherwise limited in this Agreement, Business Associate may use PHI to provide Data Aggregation services to Covered Entity as permitted by 42 CFR §164.504(e)(2)(i)(B).

d. Business Associate may use PHI to report violations of law to appropriate Federal and State authorities, consistent with 42 CFR §164.502(i)(1).


a. Covered Entity shall notify Business Associate of any limitation(s) in its notice of privacy practices of Covered Entity in accordance with 45 CFR §164.520, to the extent that such limitation(s) may affect Business Associate’s use or disclosure of PHI.

b. Covered Entity shall notify Business Associate of any changes in, or revocation of permission by Individual to use or disclose PHI, to the extent that such changes may affect Business Associate’s use or disclosure of PHI.

c. Covered Entity shall notify Business Associate of any restriction on the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 CFR §164.522, to the extent that such restriction may affect Business Associate’s use or disclosure of PHI.

6. Permissible Requests by Covered Entity. Covered Entity shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under the Privacy Rule if done by Covered Entity.

7. Term and Termination.

a. Term. The effective date of this Agreement shall be the date first stated above. This Agreement shall terminate when all of the PHI provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if it is infeasible to return or destroy PHI, protections are extended to such information in accordance with the termination provisions in this Section.

b. Termination for Cause. Upon Covered Entity’s knowledge of a material breach by Business Associate, Covered Entity shall:

1) Provide an opportunity for Business Associate to cure the breach or end the violation within thirty (30) days after written notice and, if Business Associate does not cure the breach or end the violation within that time, terminate this Agreement; or

2) Immediately terminate this Agreement upon written notice if Business Associate has breached a material term of this Agreement and cure is not possible as determined at the sole discretion of Covered Entity; or

3) If neither termination nor cure is feasible, report the violation to the Secretary of the Department of Health and Human Services.

c. Effect of Termination.

1) Except as provided in paragraph (2) of this subsection, upon termination of this Agreement, for any reason, Business Associate shall return or destroy all PHI received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision shall apply to PHI that is in the possession of any subcontractors or agents of Business Associate, and Business Associate has the duty to ensure that any and all of its subcontractors or agents comply with these termination provisions. Neither Business Associate, nor any of its subcontractors or agents, shall retain any copies of PHI upon termination of this Agreement.

2) In the event that Business Associate determines that returning or destroying the PHI is infeasible, Business Associate shall provide to Covered Entity written notification of the conditions that make return or destruction infeasible thirty (30) calendar days prior to the termination of the Agreement or within thirty (30) calendar days of Business Associate’s receipt of notice from Covered Entity of a material breach of this Agreement by Business

HPASF.021(b)
Origination date: 4/29/2015
Associate. Upon mutual agreement of the parties that return or destruction of PHI is infeasible, Business Associate shall extend the protections of this Agreement to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such PHI.

8. Effect on Prior Business Associate Agreements: This Agreement supersedes and replaces any existing Business Associate Agreement in effect between Business Associate and Covered Entity. Any PHI Business Associate has received from Covered Entity prior to, on, or after the date of this Agreement is subject to the terms and conditions of this Agreement.

   a. Regulatory References. A reference in this Agreement to a section in the Privacy Rule means the section as in effect or as amended.
   b. Amendment. The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for Covered Entity to comply with the requirements of the Privacy Rule and HIPAA; amendments are not effective unless in writing, signed by both parties.
   c. Survival. The respective rights and obligations of Business Associate under Section 7, "Effect of Termination," and Section 2.j., regarding Indemnification, of this Agreement shall survive the termination of this Agreement.
   d. Interpretation. Any ambiguity in this Agreement shall be resolved to permit Covered Entity to comply with the Privacy Rule.
   e. Notice. Any notice required under this Agreement shall be sent by certified mail, return receipt requested or by hand delivery to the following persons:

      Covered Entity:

      __________________________________________
      Name

      1115 West Call Street, Tallahassee, FL 32306-4300
      Address

      Business Associate:

      __________________________________________
      Name

      __________________________________________
      Address
IN WITNESS THEREOF, the parties have caused this Agreement to be duly executed by their duly authorized representatives as of the date last written below.

FLORIDA STATE UNIVERSITY
COLLEGE OF MEDICINE

_________________________
Authorized Representative Signature

Date:______________________

Authorized Representative Name:

_________________________
Authorized Representative Title:

Name of Business Associate

_________________________
Authorized Representative Signature

Date:______________________

Authorized Representative Name:

_________________________
Authorized Representative Title:

HPASF.021(b)
Origination date: 4/29/2015
Exhibit A

Form of Notification to Covered Entity of Breach of Unsecured PHI

Business Associate hereby notifies Covered Entity that there has been a breach of unsecured protected health information (PHI) that Business Associate has used or has had access to under the terms of the Business Associate Agreement.

Description of the breach: ____________________________________________________________

_______________________________________________________________________________

Date of the breach: _________________________________________________________________

Date of the discovery of the breach: _________________________________________________

Name of each individual affected by the breach: _________________________________________

_______________________________________________________________________________

The types of unsecured PHI that were involved in the breach (such as full name, Social Security number, date of birth, home address, account number, or disability code): __________________________________

_______________________________________________________________________________

_______________________________________________________________________________

Description of what Business Associate is doing to investigate the breach, to mitigate losses, and to protect against any further breaches: ________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

Contact information to ask questions or learn additional information:

Name: __________________________________________________________________________

Title: __________________________________________________________________________

Address: _________________________________________________________________________

Email Address: ____________________________________________________________________

Phone Number: ____________________________________________________________________

HPASF.021(b)
Origination date: 4/29/2015
Emergency Access Procedures

If an emergency occurs at our facility which will require a workforce member to access ePHI that he/she does not usually have authorization to access, but is required to access in order for a patient to receive treatment, we will do the following:

1. The workforce member involved nearest the emergency situation will be designated to access the patient’s PHI.
2. The workforce member will access the minimum PHI necessary in order for the patient to receive treatment; either paper or electronic PHI may be accessed.
3. The workforce member will log the access to the PHI; what was accessed and for what treatment reason.
4. The HIPAA Compliance Officer will audit the access to the PHI to ensure that appropriate access was made by the workforce member.

Emergency Contact Lists

The following list of contacts is maintained and should be notified in the event of an emergency.

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone</th>
<th>Alternate Phone</th>
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</thead>
<tbody>
<tr>
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</table>

HPASF.022
Origination date: 8/10/2015
The Florida State University College of Medicine
Compliance Program Policies and Procedures
Complaints (form HPAPF.014(6a))

<table>
<thead>
<tr>
<th>Product</th>
<th>Description</th>
<th>Serial / ID</th>
<th>Purchase Date</th>
<th>Location</th>
<th>Responsible Individual</th>
<th>Criticality</th>
<th>Damaged Yes / No</th>
<th>Sanitized (date)</th>
<th>Disposed (date)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

HPASF.023
Origination date: 4/29/2015
Information that should be included:
Software
Hardware (e.g. servers)
Computers
Laptops
PDAs / Smart Phone
Fax machines
Clinical Equipment

Criticality:
As part of the practices disaster recovery plan each asset is ranked on how critical it is to the operations of the practice and maintaining HIPAA Security. Criticality is used to determine priority for replacing equipment or applications should a disaster occur.

1 – Highly Critical
2 – Moderately Critical
3 – Low Priority

Damaged:
In the event of a disaster, the practice will review all equipment and IT assets to determine loss or damage.

Sanitized:
Prior to discontinuing the use of all equipment that may contain PHI, the practice has removed / sanitized all personal health information. Please indicate date.

HPASF.023
Origination date: 4/29/2015
The Florida State University College of Medicine  
Compliance Program Policies and Procedures  
for medical practices administered by the Florida Medical Practice Plan, Inc. (FMPP)

**HIPAA Policies and Procedures**  
SECURITY RULE

**Visitor Log**

<table>
<thead>
<tr>
<th>Date</th>
<th>Visitor's Name</th>
<th>Time In</th>
<th>Time Out</th>
<th>Reason for Visit</th>
<th>Signature</th>
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</table>

HPASF.024  
Origination date: 8/10/2015
HIPAA Policies and Procedures
SECURITY RULE

Facility Maintenance Record

All facility repairs or modifications which are related to security are documented. Examples may include (but not limited to) repairs or modifications done to hardware, security systems, walls, doors and locks.

Description of repair or modification:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Reason(s) for Change(s):

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Date of Repair(s): __________________________

Signature (administrator) ___________________________________________ Date: ______________

HPASF.025
Origination date: 4/29/2015
The Florida State University College of Medicine
Compliance Program Policies and Procedures
for medical practices administered by the Florida Medical Practice Plan, Inc. (FMPP)

**HIPAA Policies and Procedures**
**SECURITY RULE**

**Employee IT Access List**
The administrator or security officer is responsible for reviewing IT access rights and determining appropriate access levels for each employee. The Employee IT Access List maintains a list of what systems employees have access to along with their usernames. The Form is reviewed on a periodic basis and updated as needed to ensure appropriate authorization and access.

<table>
<thead>
<tr>
<th>Employee Name</th>
<th>Job Title/Position</th>
<th>Access Rights (list all systems, software, hardware employee has access rights)</th>
<th>Assigned User Name</th>
<th>Access is appropriate for Job Title / Position</th>
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</table>

HPASF.032
Origination date: 4/29/2015
HIPAA Policies and Procedures
PRIVACY RULE

Identity Verification

<table>
<thead>
<tr>
<th>Date</th>
<th>Patient's Name</th>
<th>Representative's Name</th>
<th>Government issued documentation</th>
<th>Verbal authorization by</th>
<th>Signature</th>
</tr>
</thead>
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</tbody>
</table>
SAMPLE FORM -
WORKPLACE SAFETY
Sample Blood and Body Fluid Exposure Report Form

Facility name: __________________________________________

Name of exposed worker: Last: ___________________________ First: ___________________________ ID #: ___________________________

Date of exposure: ______ / ______ / ________ Time of exposure: ______:____ AM PM (Circle)

Job title/occupation: __________________________________ Department/work unit: ___________________________

Location where exposure occurred: _________________________________________________________________

Name of person completing form: _________________________________________________________________

Section I. Type of Exposure (Check all that apply.)

☐ Percutaneous (Needle or sharp object that was in contact with blood or body fluids) (Complete Sections II, III, IV, and V.)

☐ Mucocutaneous (Check below and complete Sections III, IV, and VI.)
  ☐ Mucous Membrane
  ☐ Skin

☐ Bite (Complete Sections III, IV, and VI.)

Section II. Needle/Sharp Device Information
(If exposure was percutaneous, provide the following information about the device involved.)

Name of device: ___________________________________________ ☐ Unknown/Unable to determine

Brand/manufacturer: ________________________________________ ☐ Unknown/Unable to determine

Did the device have a sharps injury prevention feature, i.e., a “safety device”? ☐ Yes ☐ No ☐ Unknown/Unable to determine

If yes, when did the injury occur?

☐ Before activation of safety feature was appropriate

☐ During activation of the safety feature

☐ Safety feature improperly activated

Safety feature failed after activation

Safety feature not activated

Other: ___________________________

Describe what happened with the safety feature, e.g., why it failed or why it was not activated: _____________________________________________

Section III. Employee Narrative (Optional)

Describe how the exposure occurred and how it might have been prevented: _____________________________________________

NOTE: This is not a CDC or OSHA form. This form was developed by CDC to help healthcare facilities collect detailed exposure information that is specifically useful for the facilities' prevention planning. Information on this page (#1) may meet OSHA sharps injury documentation requirements and can be copied and filed for purposes of maintaining a separate sharps injury log. Procedures for maintaining employee confidentiality must be followed.
Section IV. Exposure and Source Information

A. Exposure Details: (Check all that apply.)

1. Type of fluid or material (For body fluid exposures only, check which fluid in adjacent box.)
   - Blood/blood products
   - Visibly bloody body fluid*
   - Non-visibly bloody body fluid*
   - Visibly bloody solution (e.g., water used to clean a blood spill)

   *Identify which body fluid
   - Cerebrospinal
   - Urine
   - Synovial
   - Amniotic
   - Sputum
   - Peritoneal
   - Pericardial
   - Saliva
   - Semen/Vaginal
   - Pleural
   - Feces/Tract
   - Other/Unknown

2. Body site of exposure. (Check all that apply.)
   - Hand/finger
   - Eye
   - Mouth/nose
   - Face
   - Arm
   - Leg
   - Other (Describe: ____________________________)

3. If percutaneous exposure:
   - Depth of injury (Check only one.)
     - Superficial (e.g., scratch, no or little blood)
     - Moderate (e.g., penetrated through skin, wound bled)
     - Deep (e.g., intramuscular penetration)
     - Unsure/Unknown
   - Was blood visible on device before exposure?  
     - Yes
     - No
     - Unsure/Unknown

4. If mucous membrane or skin exposure: (Check only one.)
   - Approximate volume of material
     - Small (e.g., few drops)
     - Large (e.g., major blood splash)
   - If skin exposure, was skin intact?  
     - Yes
     - No
     - Unsure/Unknown

B. Source Information

1. Was the source individual identified?  
   - Yes
   - No
   - Unsure/Unknown

2. Provide the serostatus of the source patient for the following pathogens.

   HIV Antibody  
   - Positive
   - Negative
   - Refused
   - Unknown

   HCV Antibody  
   - Positive
   - Negative
   - Refused
   - Unknown

   HbsAg  
   - Positive
   - Negative
   - Refused
   - Unknown

3. If known, when was the serostatus of the source determined?
   - Known at the time of exposure
   - Determined through testing at the time of or soon after the exposure
Section V. Percutaneous Injury Circumstances

A. What device or item caused the injury?

<table>
<thead>
<tr>
<th>Device</th>
<th>Selection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hollow-bore needle</td>
<td></td>
</tr>
<tr>
<td>Hypodermic needle</td>
<td>□ Attached to syringe □ Attached to IV tubing □ Unattached</td>
</tr>
<tr>
<td>Prefilled cartridge syringe needle</td>
<td>□ Attached to syringe, tube holder, or IV tubing □ Unattached</td>
</tr>
<tr>
<td>Winged steel needle (i.e., butterfly type devices)</td>
<td></td>
</tr>
<tr>
<td>IV style</td>
<td>□ Suture needle</td>
</tr>
<tr>
<td>Phlebotomy needle</td>
<td></td>
</tr>
<tr>
<td>Spinal or epidural needle</td>
<td></td>
</tr>
<tr>
<td>Bone marrow needle</td>
<td></td>
</tr>
<tr>
<td>Biopsy needle</td>
<td></td>
</tr>
<tr>
<td>Huber needle</td>
<td></td>
</tr>
<tr>
<td>Other type of hollow-bore needle (type: _______)</td>
<td></td>
</tr>
<tr>
<td>Hollow-bore needle, type unknown</td>
<td></td>
</tr>
<tr>
<td>Suture needle</td>
<td></td>
</tr>
<tr>
<td>Glass</td>
<td></td>
</tr>
<tr>
<td>Capillary tube</td>
<td>□ Pipette (glass)</td>
</tr>
<tr>
<td>Slide</td>
<td></td>
</tr>
<tr>
<td>Specimen/test/vacuum</td>
<td></td>
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<tr>
<td>Other:</td>
<td></td>
</tr>
<tr>
<td>Other sharp objects</td>
<td></td>
</tr>
<tr>
<td>Bone chip/chipped tooth</td>
<td>□ Bone cutter</td>
</tr>
<tr>
<td>Bone cutter</td>
<td>□ Bovie electrocautery device</td>
</tr>
<tr>
<td>Bur</td>
<td>□ Explorer</td>
</tr>
<tr>
<td>Extraction forceps</td>
<td>□ Elevator</td>
</tr>
<tr>
<td>Histology cutting blade</td>
<td>□ Lancet</td>
</tr>
<tr>
<td>Pin</td>
<td>□ Razor</td>
</tr>
<tr>
<td>Retractor</td>
<td>□ Rod (orthopaedic applications)</td>
</tr>
<tr>
<td>Root canal file</td>
<td>□ Scaler/curette</td>
</tr>
<tr>
<td>Scalpel blade</td>
<td>□ Scissors</td>
</tr>
<tr>
<td>Tenaculum</td>
<td>□ Trocar</td>
</tr>
<tr>
<td>Wire</td>
<td>□ Other type of sharp object</td>
</tr>
<tr>
<td>Wire</td>
<td>□ Sharp object, type unknown</td>
</tr>
<tr>
<td>Other device or item</td>
<td></td>
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<tr>
<td>Other:</td>
<td></td>
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</tbody>
</table>

B. Purpose or procedure for which sharp item was used or intended.

(Select one procedure type and complete information in corresponding box as applicable.)

- Establish intravenous or arterial access (Indicate type of line.)
- Access established intravenous or arterial line (Indicate type of line and reason for line access.)
- Injection through skin or mucous membrane (Indicate type of injection.)
- Obtain blood specimen (through skin) (Indicate method of specimen collection.)
- Other specimen collection
- Suturing
- Cutting
- Other procedure
- Unknown

<table>
<thead>
<tr>
<th>Type of Line</th>
<th>Peripheral</th>
<th>Central</th>
<th>Arterial</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reason for Access</td>
<td></td>
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<tr>
<td>Connect IV infusion/piggyback</td>
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<tr>
<td>Flush with heparin/saline</td>
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<tr>
<td>Obtain blood specimen</td>
<td></td>
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<tr>
<td>Inject medication</td>
<td></td>
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<tr>
<td>Other:</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Type of Injection</th>
<th>IM injection</th>
<th>Epidural/spinal anesthesia</th>
<th>Other injection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skin test placement</td>
<td></td>
<td></td>
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<tr>
<td>Other ID/SQ injection</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Type of Blood Sampling</th>
<th>Venipuncture</th>
<th>Arterial puncture</th>
<th>Umbilical vessel</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dialysis/AV fistula site</td>
<td></td>
<td></td>
<td>Finger/heelstick</td>
</tr>
<tr>
<td>Other blood sampling</td>
<td></td>
<td></td>
<td>Other blood sampling</td>
</tr>
</tbody>
</table>
C. When and how did the injury occur? (From the left hand side of page, select the point during or after use that most closely represents when the injury occurred. In the corresponding right hand box, select one or two circumstances that reflect how the injury happened.)

Select one or two choices:
- Patient moved and jarred device
- While inserting needle/sharp
- While manipulating needle/sharp
- While withdrawing needle/sharp
- Passing or receiving equipment
- Suturing
- Tying sutures
- Manipulating suture needle in holder
- Incising
- Palpating/Exploring
- Collided with co-worker or other during procedure
- Collided with sharp during procedure
- Sharp object dropped during procedure

Select one or two choices:
- Handling equipment on a tray or stand
- Transferring specimen into specimen container
- Processing specimens
- Passing or transferring equipment
- Recapping (missed or pierced cap)
- Cap fell off after recapping
- Disassembling device or equipment
- Decontamination/processing of used equipment
- During clean-up
- In transit to disposal
- Opening/breaking glass containers
- Collided with co-worker/other person
- Collided with sharp after procedure
- Sharp object dropped after procedure
- Struck by detached IV line needle

Select one or two choices:
- Placing sharp in container:
  - Injured by sharp being disposed
  - Injured by sharp already in container
  - While manipulating container
  - Over-filled sharps container
  - Punctured sharps container
  - Sharp protruding from open container
  - Sharp in unusual location:
    - In trash
    - In linen/laundry
    - Left on table/tray
    - Left in bed/mattress
    - On floor
    - In pocket/clothing
    - Other unusual location
  - Collided with co-worker or other person
  - Collided with sharp
  - Sharp object dropped
  - Struck by detached IV line needle

☐ During use of the item
☐ After use, before disposal of item
☐ During or after disposal of item
☐ Other (Describe): __________________________
                                  __________________________
                                  __________________________
☐ Unknown
Section VI. Mucous Membrane Exposures Circumstances

A. What barriers were used by worker at the time of the exposure? *(Check all that apply.)*

- [ ] Gloves
- [ ] Goggles
- [ ] Eyeglasses
- [ ] Face Shield
- [ ] Mask
- [ ] Gown

B. Activity/Event when exposure occurred *(Check one.)*

- [ ] Patient spit/coughed/vomited
- [ ] Airway manipulation (e.g., suctioning airway, inducing sputum)
- [ ] Endoscopic procedure
- [ ] Dental procedure
- [ ] Tube placement/removal/manipulation (e.g., chest, endotracheal, NG, rectal, urine catheter)
- [ ] Phlebotomy
- [ ] IV or arterial line insertion/removal/manipulation
- [ ] Irrigation procedure
- [ ] Vaginal delivery
- [ ] Surgical procedure (e.g., all surgical procedures including C-section)
- [ ] Bleeding vessel
- [ ] Changing dressing/wound care
- [ ] Manipulating blood tube/bottle/specimen container
- [ ] Cleaning/transporting contaminated equipment
- [ ] Other: __________________________
- [ ] Unknown

Comments:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________