VISITORS TO THE SCHOOL OF DENTAL MEDICINE
PROCESS CHECKLIST

Please follow the process below to request approval for a visitor to the School of Dental Medicine.
Applies to any visitor requesting access to the School for their own purposes rather than a business need of the School.
This checklist must be completed (Steps 1-5) at least 3 weeks prior to first visit date to avoid delays.
Visits of Undergraduate Students are limited to 2 weeks (10 business days) unless an exception is approved
Direct any questions to sodm-compliance@case.edu.

Visitor Name _____ Visitor's CWRU Network ID _____
Sponsoring Faculty Name _____ Proposed dates of visit _____
Where will visitor be what at the SODM (Buildings, Rooms, etc) _____
What will the visitor be doing while at the SODM
_____

Step 1 – Establishing a CWRU Network ID

1. If the visitor has an active CWRU Network ID (abc123), proceed to Step 2.
2. Create an Affiliate Network ID and have the visitor activate it - https://case.edu/utech/help/knowledge-base/affiliate-network-id

Step 2 – Register for required trainings. Trainings do not need to be completed to move to step 3.

1. Email hippahelp@case.edu to request the visitor be allowed access to the SODM HIPAA training in Canvas.
2. Have the visitor register for and complete the required EHS trainings
    a. Biological Safety Training - https://case.edu/ehs/training/biosafety-training
    b. Hazard Communication Training - https://case.edu/ehs/training/hazard-communication

Step 3 – Gather/Complete the following documentation. Check off as complete.

- ☐ EHS "Minors, Volunteers, and Visitors in University Laboratories Guidelines" from the New Personnel Information section on the EHS website - https://case.edu/ehs/ - **DO NOT DELETE ANY PAGES**
    Page 12 must be completed by the sponsoring faculty with details of the visit
    Page 13 must be completed and signed by the sponsoring faculty and the visitor
    Page 16 must be signed by the visitor's parent/guardian if the visitor is under the age of 18
    Page 17 must be completed if the visitor is 18 years or older
    Page 18 must be completed if the visitor is under 18 years old
    Page 19 must be signed by the faculty sponsor
    Page 20 must be completed if the visitor is a minor
- ☐ Faculty Attestation (included in this document)
- ☐ Confidentiality Agreement (included in this document)
- ☐ SODM Liability Waiver (included in this document)
- ☐ Proof of HepB vaccination/immunity if visitor will be present in the Clinic.
- ☐ If applicable, request for an exemption to the 2 week visit limit for undergraduates *(must include justification for exemption, proposed visit time frame, and activity schedule.)*

Step 4 – Confirm all required information has been collected by using the checklist below.

- ☐ By ticking this box, I confirm that an email was sent to hipaahelp@case.edu to request access to the SODM HIPAA training
- ☐ By ticking this box, I confirm that the visitor has registered for EHS trainings listed in Step 2
  Please list the scheduled dates for training: Biological Safety _____ Hazard Comm _____

Step 5 – Email all documents listed in Step 3 along with this checklist (be sure to supply a response for all fields and tick/fill in all appropriate boxes in Step 3 and Step 4) to sodm-compliance@case.edu. Documents may be sent as individual files or combined. The SODM Compliance Team will review all submitted materials for completeness. And will secure required approvals.

Step 6 – The SODM Compliance Team will email the sponsoring faculty and their Department Assistant to officially approve the visitor. **PLEASE REMEMBER** that no visitor is permitted at the School of Dental Medicine until this official approval is in place.

Revised June 9, 2026

Sponsoring Faculty Attestation for Non-Affiliated Volunteers/Visitors

As a sponsor of a non-affiliated volunteer/visitor, I understand that it is my responsibly to ensure that all School of Dental Medicine and Case Western Reserve University policies and procedures are followed by me and the volunteer/visitor.

I certify and agree to the following:

- I will ensure that I and the volunteer/visitor have provided all requested information to the School of Dental Medicine and or CWRU office prior to being admitted to any SODM restricted areas. This includes, but is not limited to:
  - SODM Non-Affiliated Persons Information form
  - Volunteer/Visitor Agreement and Confidentiality Form and completion of SODM HIPAA training
  - Proof of vaccination status (if presence in Clinical areas is requested)
  - Approved EHS form "Minors, Volunteers, and Visitors in University Laboratories Guidelines" (https://case.edu/ehs/) and proof of required trainings
  - Other information as requested by the SODM Dean's Office or its delegate.
- I will ensure that the volunteer/visitor complies with all institutional standards or policies for the duration of their time in the SODM. This includes code of conduct, dress code, safety and privacy regulations, and any restrictions based on visa type, if applicable.
- I will ensure that reasonable precautions will be taken in order to minimize disclosures of PHI to the volunteer/visitor.
- I understand that volunteers/visitors are not to be granted access to medical records unless there is a valid, approved reason for such access (e.g., an approved CWRU IRB protocol listing the visitor as a member of the study team).
- I understand that the volunteer/visitor must not participate or engage in patient care in any way.
- I understand that I must obtain verbal consent from a patient if the volunteer/visitor will be present for any clinical visit. The patient has the right not to be seen in the presence of an observer.
- I understand that I am responsible for the volunteer/visitor and must supervise them at all times when in a SODM-restricted area (i.e., any SODM space that is in an access-controlled area which the general public cannot access alone).
- I understand that if I have questions about any requirements under this agreement, it is my responsibility to contact the SODM Dean's Office and/or CWRU Compliance Office to discuss.

Name of volunteer/visitor: _____

Proposed dates of visit: _____

Sponsoring Faculty Member: _____

Sponsoring Faculty Signature: Date:

By signing below, the Department Chair acknowledges that they are in agreement with the sponsoring faculty to host the visitor in their department.

Department Chair: _____

Department Chair Signature: Date:

Volunteer/Visitor Confidentiality Agreement

Please add in the Volunteer/Visitor name in the first paragraph.

This CONFIDENTIALITY AND NON-DISCLOSURE AGREEMENT ("Agreement") is entered into as of the date of signature below by and between [ ] ("VISITOR") and Case Western Reserve University School of Dental Medicine (SODM).

The School of Dental Medicine (SODM) policies, Case Western Reserve University policies, and the Health Insurance Portability and Accountability Act (HIPAA) provisions work to protect health information and data of individuals.

HIPAA is a federal law that outlines what information is protected, how that information can be used or shared, and provides patients with certain rights regarding their information. Information that can be linked back to an individual patient regarding their medical history, mental or physical condition, treatment, test results, conversations, research records, financial or billing information and/or their family member's records is considered protected health information (PHI). Even the fact that an individual has received care at the SODM is protected by HIPAA. More information on HIPAA may be found on the following sites:

- CWRU Office of Research and Technology Management, https://case.edu/research/compliance/hipaa
- CWRU Compliance Office Policies, "HIPAA Privacy Regulations Compliance Manual", https://case.edu/compliance/university-policies
- U.S. Department of Health and Human Services, https://www.hhs.gov/hipaa/for-professionals/index.html.

As a volunteer/visitor to the SODM, I may come in contact with confidential data. These data include, but are not limited to, Protected Health Information (PHI) as described in the Federal Health Insurance Portability and Accountability Act (HIPAA), details of potential/ongoing research, and administrative processes/procedures relating to the operations of the SODM.

In order to ensure the security and proper use of confidential information and school resources, I agree to the following:

- I understand that during my time at the SODM, I may encounter confidential information and/or patient or individual protected health information (PHI).
- I understand that this information is confidential, and that the University is obligated under both federal and state laws to keep this information confidential. "Confidential Information" is defined as PHI or any and all information disclosed or known by Visitor as a consequence of visiting Case, that is not known by or available to the general public, including all oral and written information or machine-readable information accessible to VISITOR and by VISITOR, provided, however, that Confidential Information shall not include any information which:
    i. Is at the time of disclosure, or thereafter becomes known by or generally available to the public (other than as a result of a disclosure directly or indirectly by Visitor).
    ii. Is at the time of disclosure, already in the possession of or known to Visitor.
    iii. Was obtained by Visitor, either prior or subsequent to disclosure by Case from a third party not under any obligation of confidentiality to Case.
    iv. Is required to be disclosed by subpoena, governmental request, or other legally required process, provided Visitor shall not disclose such information prior to giving Case notice to afford Case an opportunity to object to such disclosure.
- I agree to keep confidential all patient information, including but not limited to, information (1) provided orally, (2) contained in patient records, (3) obtained incidentally, and (4) maintained in the School of Dentistry's electronic information systems.

- I have been advised of the importance of complying with all relevant state and federal confidentiality laws, including the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").
- I will not otherwise attempt to view, copy, or remove PHI during my visit.
- I understand that my failure to comply with the provisions of this agreement may subject me to disciplinary action by Case Western Reserve University, as well as legal action, including, but not limited to, civil or criminal prosecution.
- This Agreement will be governed by and construed in accordance with the laws of the State of Ohio.
- Should I violate this Confidentiality Agreement, I consent to permit Case Western Reserve University to release information about my violation to persons, institutions, regulatory authorities, and others having a legitimate interest in my violation, as it pertains to my fitness as a health professions student and as a licensed health care professional.
- If there is any question or confusion regarding whether information is confidential, I understand that it is my responsibility to discuss with my sponsoring faculty, SODM Dean's Office, or the CWRU Compliance Office before any disclosure is made.

This Agreement shall be effective as of the signature date below and shall continue after the end of my visit at Case.

Name of Volunteer/Visitor: _____

Signature of Volunteer/Visitor: _____

Date: _____

CASE WESTERN RESERVE UNIVERSITY
School of Dental Medicine

RELEASE AND WAIVER OF LIABILITY FORM

Name of Visitor (please print): _____

I am requesting to engage with the School of Dental Medicine as a non-affiliated visitor for the activity listed.

Activity: _____

Proposed Dates: _____

My participation may include risk. I am aware of the risks that may be encountered during this program, and I understand that the risks may include personal injury, up to and including death, and damage to property.

I have been informed of risks that may be encountered during this program, which may include, but are not limited to biohazards with bloodborne pathogens, physical or chemical hazard exposure, needlesticks, ancillary radiation (not an inclusive list). If I have any questions about the activity's content, nature, risks, or hazards, I have contacted the activity's coordinator and have discussed those questions to my satisfaction.

As a condition of participating in this activity, I agree to the following:

1. I am physically capable of participating in this activity. I understand that I am responsible for any health and accident insurance which I may deem necessary.

2. In consideration of being granted the opportunity to participate in this activity and use services and facilities furnished or made available by Case Western Reserve University as well as the assistance and advice of employees of the University, I hereby release and forever discharge Case Western Reserve University and its trustees, officers, employees, and agents from all legal claims for injuries, damages, or losses of any kind, which may arise out of my participation in this program, other than those claims directly attributable to the grossly negligent acts or omissions of Case Western Reserve University, or its trustees, officers or employees.

3. I agree to comply with all regulations, rules and policies of Case while participating in this activity. I understand that I am responsible for any medical or other personal insurance that I may deem necessary. I also understand that Case Western Reserve

University is not responsible for my safety under any circumstances.

4. I understand that the School of Dental Medicine and/or Case Western Reserve University may terminate my participation in this activity at any time for any reason at its sole discretion.

I certify that I have fully read this release and that I understand its terms and conditions and agree to be bound by them. I certify that I have executed this agreement of my own free will. I hereby acknowledge and represent that I am signing this release voluntarily, that I am at least eighteen (18) years of age and fully competent. If the individual participating is a minor child under the age of eighteen years, I certify that I am the adult parent or guardian of the participant and that I consent to his/her participation in this activity.

* Guidelines are subject to change based on evolving health guidance from University leaders and/or public health experts.

_____		
Visitor Signature	Date	Cell Phone

For participants under the age of 18:

Parent/Guardian Signature: _____ Date: _____

Printed Name: _____ Cell Phone: _____

Optional Information

Emergency Contact Information (please print)

Name: _____ Relationship: _____ Phone: _____

Medical Insurance Company Name: _____