

College of Pharmacy
Office of Student Affairs-Admissions

April 12, 2013

Dear First Year Pharmacy Student:

Your results from the Criminal Background Check have been received and the Admissions Committee has officially granted you clearance for admittance into the Class of 2017! Again, congratulations on your offer of admission to the College of Pharmacy at Howard University. All information provided in this letter will also be available for your convenience on a password protected area of our website (in May 2013), by clicking the *Events* tab and *Class of 2017* link on our new website at www.pharmacy.howard.edu. *However, be sure to keep this letter as a quick reference tool for pending deadlines.*

Username: pharmdusers Password: pharmd2013!

FINANCIAL AID

If you have not already submitted an application for financial aid, it is not too late. Please visit www.fafsa.ed.gov to apply for Federal Student Aid (Federal School Code: 001448). Students who have applied for financial aid and are eligible will be packaged in June 2013 by the University's Office of Financial Aid. Please contact the Financial Aid at (202) 806-2820 or via their website http://www.howard.edu/financialaid/contacts/staff-finaid.htm should you have any questions or concerns regarding grants and loans. Please contact the Office of Student Financial Services at (202) 806-2570 or http://www.howard.edu/studentfinancialservices/staff directory.htm if you have any billing, payment or loan disbursement issues.

MEDICAL HISTORY AND IMMUNIZATION REQUIREMENTS

Compliance with the Health Professions Immunization Requirements and Medical History is mandatory and your medical clearance is a prerequisite for registration. Therefore at this time, all new Doctor of Pharmacy students must complete the Medical History, Immunization History Record, and Physical Examination Form (which also includes the 2-Step PPD and Tuberculosis Screening) for Health Professions Students, prior to coming to campus. *The forms should be submitted directly to the Student Health Center as soon as possible, but no later than July 1, 2013 to avoid a medical hold.* These documents can be downloaded through the Student Health Center website http://www.howard.edu/studenthealth/MedicalForms.htm and are included in this e-mail for your convenience.

HOUSING INFORMATION

Students planning to reside On Campus need to contact the Howard Plaza Towers East at (202) 797-7148 or (202) 232-2897 for Graduate/Honors Housing Move-In information; ask for Ms. JoAnn Watson, or contact her via e-mail at j_watson@howard.edu. There is also additional Graduate/Professional Housing available through the Office of Residence Life at (202) 806-0943 (Mays Hall—Located on the School of Divinity campus). Applications can be obtained from the Office of Residence Life website at http://www.howard.edu/residencelife/reshalls/Mays.htm.

INTERNATIONAL STUDENTS ONLY

Please visit the Office of International Student Services Mr. Peter Ugbong at (202) 806-7296 or https://www.howard.edu/internationalservices/forms.html should you need any assistance with SEVIS and student visa transfer information/processing.

MENTORING PROGRAM

The College of Pharmacy, Office of Student Affairs is proud to announce the **Pharmacy Initiative Leaders (PILs)** program. This is a new program set to be implemented in May 2013 which will allow Howard University Doctor of Pharmacy upper-class students to connect with pre-pharmacy level and newly matriculating students who respectively have a general interest in the field and aspire to be pharmacist.

The bridge from undergraduate studies to professional school can be an arduous one; having a mentor to guide you through this process is a pivotal opportunity that many of our current students wish they had in the past.

WHAT IS PILS?

As a Mentee of PILs, newly matriculating first year Howard Pharmacy students would have the opportunity during the summer months and academic school year, to receive counseling and guidance from upper-class students, whom will give insight on pharmacy school and assist with the steps needed to succeed at the next respective level. Should you be interested in participating in this program, please send an e-mail to marlon.prince@howard.edu, with the information provided below. Once paired to a mentor, mentees will be contacted with their mentor's name, phone number and email address, by Mr. Prince. Feel free to contact your mentor if you do no hear from him/her within 2 weeks of Mr. Prince's email response.

Name:

E-Mail Address: Phone Number: Mentor Gender Preference: Pharmacy Career Interest:

For more Information contact:

Mr. Marlon Prince, PILs Advisor

(202) 806-6533, marlon.prince@howard.edu

Mr. Bryan Sackey, Student Coordinator (240) 398-9760, <u>bryan.sackey@gmail.com</u>

ORIENTATION REQUIREMENTS

The Office of Student Affairs is in the process of compiling the Orientation Packets to all NEW students and will be mailed by June 2013. Included in that packet will be the Week-Long Orientation Scheduled, fall 2013 Class Schedule and the fall 2013 Booklist. *Orientation is mandatory and tentatively scheduled for the week of August 19, 2013.* The first day of class is Monday, August 26, 2013.

WHITE COAT CEREMONY INFORMATION

ALL first year students will receive complimentary Lab Coats at the White Coat Ceremony, during the week of Orientation. Please provide us with your lab coat size via e-mail. Be sure to include in the e-mail your full name and the undergraduate or graduate institution you attended previously.

Please Note: You may want to order your lab coat 2 sizes larger than your regular size, as the coats run small and will need to be worn over your professional attire. **Be sure to provide your lab coat size to me no later than Friday, June 29, 2012**. Men sizes are according to your Suit Jacket (ex. 42 or 42 Long). Women sizes are according to your dress size (ex. Size 12).

The Center of Excellence is in the process of compiling the Program Booklet for the White Coat Ceremony. Each New Student Pharmacist will be featured with their biographical sketch. Please submit your biographical sketch to Ms. Celia Williams-Fowlkes via e-mail at celia.williamsfowl@howard.edu no later than Friday, August 2, 2013. Please use the sample guide below for uniformity.

SAMPLE:

Ms. Jane Doe is a native of Miami, Florida. She graduated from the University of Florida in May 2013 with a Bachelor's of Arts Degree in Spanish and a concentration in Pre-Pharmacy. At the University of Florida, she was an active member of the Pre-Pharmacy Society, Foreign Language Organization, and Student Council. She has worked for the last 3 years as a Pharmacy Technician at CVS Pharmacy. Upon completion of the Doctor of Pharmacy Degree Program at Howard University, she plans to start her career meeting the demanding health care needs of her community.

PARKING

Parking is limited and requires permits for all University lots. For more information on parking, please visit their website at http://auxiliary.howard.edu/parking-policies.html#.

PHARMACY BIOMEDICAL PREVIEW PROGRAM (July 8-August 9, 2013)

To ensure you will make a valuable contribution to the University's tradition of scholarship and service, the College of Pharmacy's Center of Excellence Program is offering a FREE Pharmacy Biomedical Preview (PBP) Program.

The PBP Program is a **five-week**, on-site and online non-stipend summer enrichment program, scheduled July 8-August 9, 2013. The purpose of the PBP Program is to expose new entering student pharmacists early to the Basic Sciences component of the Pharm. D. curriculum with the expectation of improving the overall preparation for students in the Pharm. D. curriculum. This PBP Program will offer a jumpstart to first year student pharmacists in Pharmaceutical Mathematics, Biomedical Sciences I (Anatomy/Physiology), and Biomedical Sciences II (Biochemistry/Microbiology) while providing them with an opportunity to prepare, organize and assimilate new scientific knowledge. Classes will meet Monday through Friday from 9:00 a.m. to 5:00 p.m. in the College of Pharmacy [Chauncey Cooper Hall (CCH) Building], Room 207.

Due to the rigors of the Doctor of Pharmacy curriculum, <u>ALL new incoming students are highly recommended</u> to participate in this program. Housing will not be provided through this program; therefore students need to make appropriate living arrangements. However, in an effort to make this program accessible to all students, <u>we are pleased to announce the PBP Program will also be available ONLINE!</u> Course credit will also be provided to students who participate in all assessment activities, and successfully complete the program.

Please visit our website <u>www.pharmacy.howard.edu</u> for more information and the registration process (click on the *Center of Excellence* tab, then the *Pharmacy Biomedical Preview Program* link). Be sure to indicate whether you will attend the program in person, or online. Details regarding the access of the program online will be available on our website July 1st, 2013. Please note: <u>Students accepted with the specific condition of successful completion of the PBP Program must participate in person (on-site), as additional one-on-one tutorial support and access to faculty will be offered.</u>

LAPTOP POLICY PROGRAM

LAPTOP REQUIREMENT POLICY

All pharmacy students are required to own a laptop that meets minimum specifications set by the program.

Purpose:

Since 2000, the College of Pharmacy has sought to increase the use of computer software and hardware for three primary purposes.

- 1. The first objective is to improve overall instructional efficiency and retention resulting in improved student outcomes.
- 2. The second objective is to minimize costs to students for printing and photocopying. As an example, the vast majority of student lecture notes are in text and/or Microsoft Power Point slides.
- 3. To ensure that each student has a minimum baseline set of technical skills.
- 4. To accommodate taking computerized exams for all College of Pharmacy required courses.

FINANCIAL AID IMPACT

The Howard University College of Pharmacy has developed a Laptop Requirement Policy that addresses the academic demands of the Pharmacy curriculum while taking into consideration restrictions and qualifications mandated by the Federal Student Aid (FSA) Cost of Attendance Budget. For an explanation regarding the Cost of Attendance Budgets, please visit the following http://ifap.ed.gov/fsahandbook/attachments/Vol3Ch21213Jun14.pdf.

In an effort to reduce overall out of pocket expense to students, laptops have been included in the calculations for the College of Pharmacy's Cost of Attendance Budget in the amount of \$1400.00. This inclusion allows all students the financial means for meeting the basic needs of the laptop requirement.

Cost Of Attendance Budget Calculations (College Of Pharmacy-Year One)

Pharmacy 1st Year	Academic Year (11 Months)				
Tuition	\$27,977.00				
Mandatory Fees	\$1,233.00				
Clinical Lab Fee	\$200.00				
Professional Fee	\$400.00				
Laptop Computer	\$1,400.00				
Books & Supplies	\$2,509.00				
Loan Fees - Unsubsidized	\$250.00				
Loan Fees - PLUS	\$869.00				
Room	\$13,101.00				
Board	\$10,120.00				
Transportation	\$3,036.00				
Incidentals	\$2,500.00				
Total	\$63,595.00				

Minimum Windows PC Laptop Specifications:

Hardware minimum requirements:

- ✓ 2.1 GHz Intel Core Duo (or equivalent)
- √ i5 or greater processor recommended
- ✓ 250 GB hard drive
- ✓ 4 GB RAM
- ✓ DirectX 9 graphics device with WDDM 1.0 or higher driver
- ✓ Wi-Fi 802.11 g/b/n wireless card
- ✓ USB ports
- ✓ Monitor screen size minimum 12.1" diagonal

Software minimum requirements:

- ✓ Windows 7 Professional 64-bit OS (Avoid Windows 7 Home Premium)
- ✓ Microsoft Office (2007, 2010 or greater)

- ✓ Adobe Acrobat reader (latest version) (Free downloads)
- ✓ Antivirus software, Firewall software
 - You must have professional anti-virus software installed and up-to-date in order to use the university's wireless network. The Department of Enterprise Technology Services (ETS) at Howard University provides Symantec Endpoint Virus Protection to all Howard University registered students available for download at https://secure.howard.edu/dana-na/auth/url_default/welcome.cgi, free of charge.
- ✓ Windows media player (latest version)
- ✓ QuickTime player (latest version) (Free downloads)
- ✓ Sun Java (Free downloads)
- ✓ Adobe Flash/Shockwave (Free downloads)

Macintosh:

Hardware minimum requirements:

- ✓ 2.4 GHz Intel Core Duo (or equivalent)
- ✓ 250 GB hard drive
- ✓ 4 GB RAM
- ✓ Wi-Fi 802.11 g/b/n wireless card
- ✓ Bluetooth capability
- ✓ USB ports
- ✓ Monitor screen size minimum 12.1" diagonal

Software minimum requirements:

- ✓ Snow Leopard OS
- ✓ Microsoft Office (2008 or 2011)
- ✓ Adobe Acrobat reader (latest version)
- ✓ QuickTime player (latest version)
- ✓ Windows Media Components for QuickTime (latest version)
- ✓ Adobe Flash/Shockwave

The College of Pharmacy faculty is aware of potential limitations of the Macintosh OS compatibility with some Windows OS native applications. The Macintosh user options:

- 1. Boot Camp. Boot Camp is an application native in Macintosh OS and will allow the user to select the OS at startup (Macintosh or Windows)
- 2. Purchase of a virtual machine emulation program (Parallels or VMWare Fusion) that will allow for simultaneous computing on both OS.
- 3. Please read for more information: http://www.apple.com/osx/what-is/compatibility.html. Recommended (but not required):
- External hard drive (100 GB)
- Web camera
- DVD/optical drive (internal or external)

Before you arrive on campus, you must have updated your operating system to its latest service pack. For Windows 7, this is Service Pack 1. To make sure that your system is up-to-date, open the Start menu and choose Windows Update.

HIPAA Compliance:

Patient confidentiality and privacy is of utmost concern. It will be up to the students to be cognizant of any and all computerized/digitized patient information and be in compliance with the Health Insurance Portability and Accountability Act (HIPAA). Therefore it is strongly recommended that students be engaged in encrypting their USB Flash Drives and enabling security features on their computer

Recommended Warranty Coverage & Service Plan:

It is highly recommended that you obtain a warranty and service plan that will cover your laptop during your years of study at Howard University's College of Pharmacy. The warranty and service plan should cover a four year period. If possible, select an on-site service plan. If an accidental damage warranty is available, it is recommended to add that as well.

ACKNOWLEDGEMENT OF THE COLLEGE OF PHARMACY'S LAPTOP REQUIREMENT POLICY

The Laptop Requirement Policy participation is a condition of your acceptance into the College of Pharmacy. Please find the Laptop Requirement Policy Acknowledgment Statement Receipt on the last page. This Receipt must be signed and returned to the College of Pharmacy on the first day of Orientation.

All entering Doctor of Pharmacy students must have a laptop which is in compliance with the Laptop Requirement Policy during their years of study at Howard University, no waivers will be allowed!

Thank you for taking the time to read this document completely. If you have questions regarding any events, please contact Mr. Marlon Prince at (202) 806-6533 or Mrs. Terry Morris (202) 806-5009.

We look forward to having you join us in fall 2013, and contributing to Howard University's Legacy of Leadership for America and the Global Community. Your experience at "The Capstone" will be exciting, rewarding and memorable! Once again, welcome to Howard!

Sincerely,

Youness R. Karodeh, Pharm. D., R.Ph.

Assistant Dean

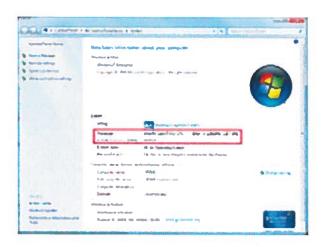
DETERMINE SYSTEM PROPERTIES IN WINDOWS 7

Summary

The System Properties panel provides basic information about your system, including processor speed and system RAM or memory. This information is often important when troubleshooting system performance or for determining product compatibility. This article provides instructions to find the system properties information on your Windows 7 machine.

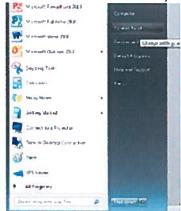
Review Processor and Memory (RAM) Information

- 1. Click on the Start Menu, and locate Computer.
- 2. Right-click Computer and select Properties. This will call up the System Properties dialog box.
- 3. The second and third lines in the System field provide the system's processor and memory specifications.

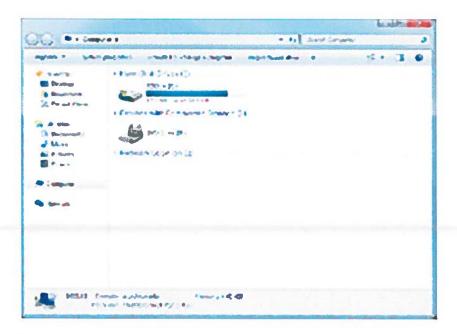


Review Hard Drive Information

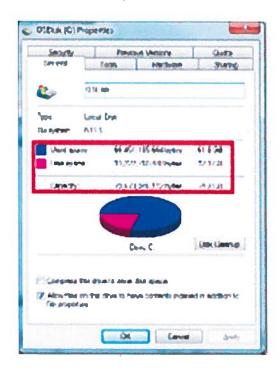
1. Click on the Start Menu, and click on Computer



2. The Computer window will appear:

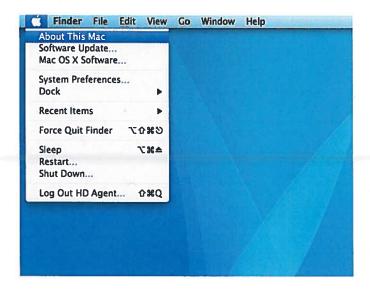


- 3. Right-click on the Hard Disk Drives heading and select Properties.
- 4. The Properties dialog of your drive provides information about the total capacity of hard drive, amount of space used, and amount of space available as shown below:



MAC OS X CHECK SYSTEM INFORMATION

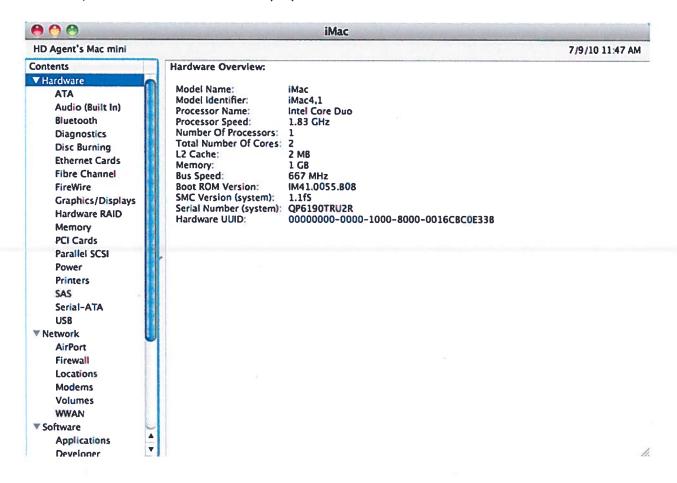
• Click the Apple icon in the top left, and select About This Mac.



• For more advanced details click More Info... in the About This Mac window.



• System information will be displayed as shown:





Laptop Requirement Policy Statement Receipt

Howard University College of Pharmacy Laptop Requirement Policy has been provided and contains all relevant information required for the edification of all newly enrolled students in Howard University's Doctor of Pharmacy program. The information contained in this policy is subject to change without prior notice and is not to be construed as a contract between the College or University and the student. By signing the Howard University College of Pharmacy Laptop Requirement Policy Statement Receipt, students are acknowledging receipt of the Laptop Requirement Policy and accepting responsibility to thoroughly become familiar with the information found within and to comply with the policy. Receipts must be signed and returned to the Office of Student Affairs during the week of Orientation. Copies of the signed receipt will be kept in an individual's file.

I, the undersigned, acknowledge that I have received a copy of the Howard University College of Pharmacy Laptop Requirement Policy, its meaning and implication, and how it impacts on my educational plans and future professional goals at Howard University. Furthermore, I concede to become thoroughly familiar with and fully comply with this Policy and understand that information contained within is subject to change without prior notice.

Name:	ID #: @	
Signature:	Date:	

PLEASE NOTE:

Failure to read, understand and interpret this Howard University College of Pharmacy Laptop Requirement Policy does not excuse students from the professional and academic risks described therein. Furthermore, personal factors, illness, or contradictory advice from any source are not acceptable grounds for seeking exemption from this policy and procedures.



TO: NEW ENTRANTS, PARENTS, TRANSFER STUDENTS AND FORMER STUDENTS RETURNING:

The Student Health Center staff extends a warm welcome to all. All students entering a school or college of the University for the first time or returning after an absence of a semester or more, are required to submit a completed **Report of Medical History as well as an Immunization and Tuberculosis**Screening Certificate signed by a licensed health care provider. Please note that there is a separate Immunization and Tuberculosis Screening

Certificate form for students entering Health Professions schools as opposed to those entering Non-Health Professions schools. Enclosed in this package are all the forms that you will need to document the health requirements. If you have not received the forms with this letter, please access our website www.howard.edu/studenthealth for the most updated information and forms on the University's health requirements. You should take this letter, a copy of all of your immunization records, and the enclosed health-related forms to your health care provider for review; this will allow your health care provider to complete the forms appropriately.

Compliance with the immunization requirements is mandatory and your medical clearance is a prerequisite for registration. Therefore you should complete all medical requirements prior to coming to our campus. The forms should be submitted directly to the Student Health Center as soon as possible but no later than July 1 for Fall entrants and no later than December 1 for Spring entrants to avoid a medical hold and any unnecessary delays in your registration. Students may mail the completed forms to the Student Health Center and/or fax the forms to the Student Health Center (202-806-7416). Students should retain a copy of all documents submitted to the Student Health Center. Whenever there are questions concerning immunization compliance and/or a medical hold, the student should have on hand a copy of all immunization information submitted to the Student Health Center (do not submit the original copies of your childhood immunization records).

If for some reason a student is unable to complete the immunization requirements before presenting to Howard's campus, students may come to the Student Health Center for assistance in meeting the immunization requirements. However, students who are non compliant with the immunization requirements will be on medical hold and the student should expect to remain on medical hold.

Student Health Center 2139 Georgia Avenue, NW Washington, DC 20059 Telephone 202 806-7540 Facsimile 202 806-7416 www.howard.edu/studenthealth until he/she is compliant with all the required immunizations. Finally, let me share information with you on the Meningococcal vaccine. Meningococcal disease, a potentially fatal bacterial infection, has received much media discussion over the past several years. Even though the vaccine does not protect the student from all the strains that cause this form of meningitis, up to 83% of all cases in adolescents and young adults could have been potentially prevented by this vaccine. The CDC recommends that college students. particularly freshmen living in residence halls, be educated about meningitis and the benefits of vaccination. The recommendation further states that information about the disease and vaccination is appropriate for other undergraduate students who also wish to reduce their risk for the disease. Meningitis is rare. However, when it strikes, its flu-like symptoms make diagnosis difficult. If not treated early, meningitis can lead to swelling of the fluid surrounding the brain and spinal column as well as severe and permanent disabilities, such as hearing loss, brain damage, seizures, limb amputation and even death. On May 2, 2008, the District of Columbia Health Department regulations mandated that all students entering a college for the first time receive the meningococcal vaccine or sign a waiver. We strongly recommend that all students planning to live in University housing receive the Meningococcal vaccine before arriving on campus. Please visit our website www.howard.edu/studenthealth and learn about access to health care at Howard University.

Sincerely, Evelyn Treakle-Moore, M.D., FACP Director, Student Health

SHC 2/06-HO-13 (Revised 12/09)

HOWARD UNIVERSITY - STUDENT HEALTH CENTER CHECKLIST FOR HEALTH PROFESSIONS STUDENTS

GUIDELINES FOR COMPLETION:

- This Checklist should be used by Health Professions students to make sure that they have completed all of the requirements to receive a Health Clearance Certificate.
- A Health Clearance Certificate is required before all Health Professions students begin their clinical rotations and/or other patient care activities.
- The Health Clearance Certificate is issued by the Student Health Center and it is good for one year. It is the student's
 responsibility to make sure that their Health Clearance Certificate is current by completing the annual requirements
 before they expire.

7	ANNUAL HEALTH CLEARANCE REQUIREMENTS	
	Physical Examination Form (Submit copy of SHC PE form)	Date://
	PPD Test: A Two step PPD is required if your last PPD is > one year.	Date: 1st/ Date: Read//mm
	The 2 nd PPD must be placed (on the other arm) no earlier than a week after the first PPD but no later than 3 weeks after the first PPD is placed.	Date: 2 nd / Date: Read//mm
	Instead of PPD testing, blood test may be done:	Date:/
	*Blood Test: □ Quantiferon Gold □ T Spot	Must submit copy of lab report.
	CXR required for positive PPD, positive blood test or history of	
	positive PPD. Must submit copy of CXR radiology report.	Date:/
	Nasal Cultures for Pediatric Rotation. Must submit copy of lab report	
	for cultures done 2-3 weeks prior to starting Pediatric Rotation.	Date:/
	Stool cultures for Nutrition. Must submit copy of lab report	Date:/
	RPR Test (Must submit copy of lab report)	Date:/
	HIV Test* (Submit copy of lab report)	
	Baseline for possible blood borne exposure during rotations.	Date:/
	FIT TESTING (Scheduled by Health Professions schools)	Date:/
	INFLUENZA vaccine	Date:/ Expiration Date:/
	Health Clearance Certificate	Expiration Date:/
1	HEALTH CLEARANCE REQUIREMENTS: Submit orie time only	
	Tdap Vaccine	Date://
	Immune IgG quantitative antibody titers for MMR	Date:/
	If MMR liters are non Immune: Submit documentation of two MMR vaccines and a MMR	Date: #1/ Date: #2//
	booster shot given after date of non immune titers. Repeat liter is required Imonth after	Date: Booster// Date://
	MMR booster given.	Repeat titer
	Immune IgG quantitative antibody titers for Hepatitis B (surface antibody)	
	If Hepalitis B titlers are non Immune, Submit documentation of three Hep B vaccines and a	Date: #1/ Date: #2/
	Hep B booster shot given after date of non Immune liters. Repeat Iller is required Imonth after Hep B booster given.	Date: Booster//_ Dale://
		Repeat liter
	Immune IgG quantitative antibody titers for Varicella	Date://
	If Varicella titers are non Immune, Submit documentation of two Varicella vaccines and a	Date: #1/ Date:#2/
	Varicella booster shot given after date of non Immune titers. Repeat titer is required Imonth	Date: Booster/ Date:/ Repeat titer
	after Varicella booster given.	Date://
L_	MENINGOCOCCAL Vaccine (Highly recommended)	
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SHC 12/12-03

HOWARD UNIVERSITY STUDENT HEALTH CENTER

2139 Georgia Avenue, NW Washington, DC 20059 Phone: (202) 808-7540 Fax (202) 806-7416

Office Use Only:

Website: http://www.howard.edu/studenthealth
ATTENTION ALL HEALTH PROFESSIONS STUDENTS: Please download the Health Clearance Checklist located on our website for more detailed information on the requirements for Health Clearance prior to starting your Clinical rotation.

PHYSICAL EXAMINATION (To be completed by Medical Provider)							
Physical Examin	nation is requ	ired annua	illy.		Physic	al Exam Date	
	_		-		•		
LAST NAME		FIRST NAME		MIDDLE NAME	DATE OF BI	RTH (mo/day/yr)	CTIOTHT TO A
				THEODEL HAME	DATE OF BI	CITI (mo/gay/yr)	STUDENT ID#
TEMP	RESP	PULSE (sit	ting) B	LOOD PRESSUR	E (sitting) HEIG	GHT WEIGHT	BMI (Body Mass Index)
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• GI tract	H2M101						
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Musculo	oskeletal						
 Neurolo 	ogical						
Carried St.				PHYSICAL E	XAM		
General Appear	ance/Mental	Status:					
Check appropria	ate answer		Normal	Abnormal		Comment on ab	normalities
Head/face/scalp	ald						
Neck/nodes/ thyro Eyes/Ears/Nose/S							
Mouth and teeth	inuses						
Pharynx and tons	ile						
	illS						
Lungs and chest Breasts							
Heart (size, rhyth							
Abdomen (scars,					<u> </u>		
Genitourinary (pe					1.010470		
Anus, rectum (pro					LNMP/_		
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Peripheral vascula							
Skin and lymphat				 			÷
Neurological, refle							
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You must submit	a conv of lab	enorte for e	erological te	et for symbilis	Clearance will not	he alven without	copies of lab reports.
Serological Tes	t for Syphilis	: Name of To	est	actor application	_ Date:	Result	::
Urinalysis Date:		Protein	Gluco	se Hg/F	ict (females only)	Date:	Results:
Stool Culture: D	Date		Resul	ts	(Nutrition	n Only)	
Nasal Culture: I	Date		Result	5	(Pediatric	Rotation Only)	
							ast two PPD readings:
Date skin tes	st placed/_		Date skir	test read/_		eading in mm indura	tion:
	st placed/			test read /		eading in mm indura) was placed > one	
							the first PPD is placed)
Date 1st PPP	Placed: /	/ Date	PPD Read:	/ / Rea	iding in mm induration	on: m	m
Date 2 nd PPI	D Placed:/_	_/ Date	e PPD Read: _	//Re	ading in mm indurati	on:m on:m	ım
If PPD is positiv	ve, you must	submit a c	opy of a ch	est x-ray repo	ort done within t	he last six mont	ths.
Date of Ch	est X-Ray			Result:		_	
RESTRICTED A	CTIVITY: N	o o Yeso	Reason	for Restriction	n:		
Provider's Sign	ature and Tit	ie:				Date:	
							0:
Office/ Clinic Nat	me		C	Office/Clinic Add	ress	Cl	ty/State

PROVIDERS' GUIDELINES FOR <u>IMMUNIZATION HISTORY DOCUMENTATION</u> FOR HEALTH PROFESSIONS STUDENTS ONLY

THE STUDENT WILL REMAIN ON MEDICAL HOLD AND WILL NOT BE ALLOWED TO REGISTER UNTIL ALL IMMUNIZATION REQUIREMENTS ARE MET.

The immunization record form must have a medical provider's signature.

Dates for vaccines should include month/day/year.

<u>TUBERCULOSIS SCREENING</u>: A PPD-Mantoux test must be placed and interpreted by a healthcare provider within 6 months of registration. A student who was previously given the BCG vaccine should also receive the PPD skin test.

- The PPD documentation must include:
 - o The date (month/day/year) the PPD was placed
 - o The date (month/day/year) the PPD was read between 48 to 72 hours
 - The measured reading of the PPD (e.g., 0 mm)
 - If the skin test is positive or the student has a history of a positive skin test, then you must submit a copy of the chest x-ray results which was done within the last 6 months.
- Must document dates for the last two PPD readings:
 - A Two step PPD is required for all Health Professions students if their last PPD was placed > one year ago.
 - The second PPD must be placed no earlier than a week after the first PPD but no later than 3 weeks after the first PPD is placed
- Blood tests for Tuberculosis screening are accepted for Quantiferon Gold and T Spot only.
- o Must submit copy of lab test results done within 6 months of registration TETANUS/DIPHTHERIA: Immune titers for Td are not acceptable.
 - Tdap vaccine is required

MEASLES / MUMPS / RUBELLA (MMR): HISTORY OF DISEASE IS NOT ACCEPTED. Students are not exempt from MMR because of age (born before 1956).

- Must submit a copy of lab report for immune titers (IgG QUANTITATIVE antibodies) for MMR
 - If the MMR blood titers are non immune
 - You must submit documentation of dates for one of the following:
 - Two doses of a previously completed MMR vaccine plus a booster dose of MMR OR
 - Two doses of MMR vaccine with at least one dose given after the nonimmune titer. Repeat titers > 1 months after last MMR dose given.

<u>HEPATITIS B SERIES</u>: Submit a copy of lab report for immune titers (IGg QUANTITATIVE antibodies).

- If blood titers are non immune
 - You must submit documentation of dates for one of the following:
 - Three doses of a previously completed Hepatitis B vaccine plus a booster dose of Hepatitis B OR
 - Three doses of Hepatitis B vaccine with at least one dose given after the nonimmune titer. Repeat titers > 1 months after last Hep B dose given.
- The basic dosing schedule for the three regulred doses of Hepatitis B vaccine are:
 - o There must be 4 weeks between dose #1 and dose #2
 - o There must be 8 weeks between dose # 2 and dose #3
 - There must be 16 weeks between dose #1 and dose #3

VARICELLA (CHICKEN POX) SERIES: HISTORY OF DISEASE IS NOT ACCEPTED.

- Must submit a copy of lab report for immune titers (IGg QUANTITATIVE antibodies) for Varicella (VZ).
- If blood titers are non immune
 - o You must submit documentation of dates for one of the following:
 - Two doses of a previously completed Varicella vaccine plus a booster dose of Varicella OR
 - Two doses of Varicella vaccine with at least one dose given after the nonimmune titer. Repeat titers > 1 months after last VZ dose given.

MENINGOCOCCAL VACCINE: Highly recommended for all Health Professions students.

HOWARD UNIVERSITY - STUDENT HEALTH CENTER

IMMUNIZATION HISTORY RECORD FOR HEALTH PROFESSIONS STUDENTS ONLY

GUIDELINES FOR COMPLETION:

- This form must be completed and must include a medical provider's signature, health department stamp, or attachment of high school and / or military medical record. Submission of previous records MAY NOT fulfill all of the requirements listed below.
- Records must be documented in black ink and all corrections must be signed.
- All vaccine dates must include month, day, and year of administration.
- This Immunization record form must be returned or faxed to the STUDENT HEALTH CENTER immediately upon acceptance into Howard
 University. You may fax or mail ail completed immunizations records. YOU WILL REMAIN ON MEDICAL HOLD AND WILL NOT BE
 ALLOWED TO REGISTER UNTIL ALL REQUIREMENTS ARE MET.

Name (Last, First, Middle)		Date of Birth (mm/	dd/yr) Student	Student Identification Number		
BERCULOSIS SCREENING:						
TUBERCULOSIS SCREENING IS REQUIRED	FOR ALL STUDENTS. P	PD-Mantoux test mi	ust be placed and interprete	d by a healthcare		
provider within 6 MONTHS of registration	i. A student who was n	reviously giving the	BCG vaccine should also rea	reive the PPD skin tost		
May submit a copy of blood test for Quan						
If the skin test or blood test is positive and	d/or the student has a i	nistory of a positive	skin test, a copy of chest x-	ray radiology report with		
the last 6 MONTHS is required.						
A TWO STEP PPD IS REQUIRED FOR ALL H				the other arm) no earli		
than a week after the first PPD but no late	er than 3 weeks after th	e first PPD is placed	i.			
ase document dates for the last two PPD testing:				Negative Positive		
te 1 st Skin Test Placed://	Date 1st Skin Test Rea	d:/		Negative D Positive		
te 2 nd Skin Test Placed:// tead of PPD testing, blood test may be done:	Date 2 nd Skin Test Rea	id://	Negative (<10mm)	Positive (≥10mm)		
ood Test: Quantefiron Gold T Spot	Date of Blood Test:	. , ,	□ Negative	D Positive PY OF LAB TEST RESULT		
KIN TEST/Blood test Is POSITIVE, OR HISTORY OF	Date of Blood Test.		TAIOST SUBIVITY A COL	Y OF DAB TEST RESULT		
SITIVE TEST: Date of Positive Skin Test: / /	Date of Chest X-Ray	c / /	ATTTACH A COPY OF CHEST	X-RAY RADIOLOGY REPOI		
QUIRED IMMUNIZATIONS:						
•						
addition to the information below, you MUST SU	IBMIT A COPY OF LAB I	REPORTS FOR IMM	UNE BLOOD TITERS (IgG QU	ANTITATIVE antibodies)		
MMR, Hepatitis B, and Varicella.						
POLIO: Three doses of pollo vaccine are required for a	nyone under the age of					
18 at the time of registration.		Dose (1) Dose (2)				
TETANUS / DIPHTHERIA: Three doses of Diphtheria/Te DTaP, or DT) in childhood and a booster of Tetanus/Dij		Dose (1)/ Dose (2)/ Dose (3)/				
last 10 years. IMMUNE TITERS FOR TO ARE NOT ACCEP						
Tdap IS REQUIRED	1710627	Date of Td Booster	/ / Tdap Dose	1 1		
MEASLES / MUMPS / REBELLA (MMR)		Dose (1)//_	Dose (2)/			
Two doses required. History of disease is not acceptab	le.	Date of Immune Ti	ter://_			
HEPATITIS B		Dose (1) Dose (2) Dose (3)				
Three doses required.		Date of Immune Titer://_				
VARICELLA		Dose (1)/_	Dose (2)/ OR			
Two doses required. History of chickenpox is not acce	ptable.	Date of Immune Ti	ter://			
MENINGOCOCCAL (Highly recommended) Booster required if primary dose given before 16 th birt	thelau	Date of Dose / / Date of Booster//				
Booster required if primary dose given before 10 birt	inday.	Date of Dose/_				
MMR, Hepatitis B, or Varicella blood titers are non Im	mune, vou must submit o	documentation of the	date the booster shot was give	en. You must document d		
above for completed vaccine series for MMR (2 dose	es). Hepatitis B (3 doses).	and/or Varicella (2 do	ses). The booster shot must b	e after the date for the no		
Immune titers. Repeat titers > 1 month after boost	er dose. You must submit	a copy of lab report f	or repeat immune titers (IGg C	(UANTITATIVE antibodies)		
MEASLES / MUMPS / REBELLA (MMR) Date MMR Bo		Date of Repeat Imr				
HEPATITIS B Date Hep 8 Booster //_		Date of Repeat Immune Titer://_				
VARICELIA Date VZ Booster//_	Date of Repeat Immune Titer:/					
Print Name of Health Care Provider or Clinician	Application of the second	Signature / Health D	epartment Stamp	Date		
	W					
	Office / Clinic Ac		- ·	ephone#		

SHC 12/12-01

HOWARD UNIVERSITY STUDENT HEALTH CENTER WASHINGTON, DC 20059

Fax (202) 806-7416 Phone (202) 806-7540

The following health history is confidential and does not affect your admission status. This information is requested to determine if you have any medical conditions that may require special assistance from the University. This information will be used to help us provide continuity of care for you. This information will not be released without your written permission except in an emergency situation, by court order or by parental consent if under age 18. Please attach additional sheets for any items that require additional explanation.

(Please print in black ink)

To be completed by student

SEGTION 1: REPORT OF MEDICAL HISTORY

LAST NAME				(FIRST NAME	ST NAME MIDDLE NAME			•	STUDENT ID NUMBER				SOC. SECURITY NUMBER				
PERMANENT ADI	RESS							CITY	1		STAT			ZIP CODE	ARE	A COF	E/PH	DAIE
DATE OF BIRTH ((mo/da	ау/у	/r)	PLACE OF BIRTH										-				
EMAIL				CLASS YOU ARE ENTER FR. SO. JR. SR.				ING (cl	rde)		SE FA	MESTER ENTER LL SPRING SU AR	ING (c	irde):				
NAME OF PERSON TO CONTACT IN CASE OF EMERGENCY									RELA	TIONS	HIP							
ADDRESS CITY					-	STATE		15	ZIP C	ODE		AR	EA CO	DE/PI	IONE			
NAME AND ADDR	RESS O	FHE	EALT	H IN	SURANCE CO)							AREA	CODE/PHONE		,		
NAME OF POLICY	HOLD	DER .						1	POLICY/CE	RTIFIC	CATE	#		GROU	P#			
SECTION 2: FAM	ILY M	EDI	CAL	ніст	ORY	20	(Please	print in	black ink)	den/i		PROFES	Re III	To be co	mplete	d by s	tudent	100
HAS ANY PERSO																		
High blood pressure		\blacksquare	Yes	No	Relationship					Yes	No	Relatio	nship		Yes	No	Relatio	onship
	<u> </u>						noleste isorder	rol or bi	15t 000					Cancer (type):				
Stroke						D	labetes	3						Alcohol/drug problem				
Heart attack before	age 55	5				G	laucom	a						Psychiatric				
Blood or dotting di	sorder					TA	sthma							iilness Suicide				
SECTION 3: PER	SONA	LM	EDIC	AL H	ISTORY	1940	(Ple	ase orb	nt in black ink	1	E COST		. 12.5	To be	compl	obad b	u chude	
								-	-	-								
DO YOU HAVE A	Yes	No.	OF A	NY O ar I	F THE FOLLO	Yes	NG: I	Year	ANSWER E	ACH Q		ION AI			FOR Y		SWER No	
Anemia or Sickle					Chest Paln			700	Headaches			, 140	1601	Protein or blo	od in	1165	INO	I COI
cell anemia Anorexia/Bulimia	\vdash		+-		or pressure Chronic		+-	-	(Frequent/: Head Injur		-	urine		urine Chronic pain				
·					cough				(severe)		1			(severe/recu	rent)			
Ailergies/Hay fever				- '	Concussion				Hepatitis or Jaundice					Pneumonia				
Asthma					Cancer or Tumor				Hearing los	S				Rectal diseas	е			
Arthritis			1		Cigarettes smoking				Hemla (spe	ecify)	<u> </u>			Rheumatic or		+	1	
Alcohol/drug					Diabetes				Intestinal		+			Scarlet fever Serious skin			+	
problem Breathing			+		Dizziness or			-	problems Kidney stor	ne .	+-			disease Selzures		+	+	
problems/					fainting											\perp		
Back or neck Injury				- 1	Depression or Excessive worry				Learning d (specify)	sorder				Sexually Transmitted disease (STD	n			
Bone, joint or other deformity					Eye problem (not glasses)				Malaria					Thyroid trout				
Broken bone(specify)					Easy fatigability				Mononucle	osls				Tuberculosis				
Biadder or kidney Infection					High blood pressure				Menstrual ((severe)	cramps	5			Testicles pro	blems			
Blood transfusion					Heart condition				Physical dis	sability				Other (specif	у)			
Please complete	rever	ia es	de.					•					1			1	of 2	

SECTION 3: PERSONAL MEDICAL	HISTOR	lY – C	ONTINUED (Please print in black link)	To be completed by student					
Describe any conditions or disabilities	that wou	ıld excl	ude participation in physical education (e.g., swim						
Do you exercise three or more times per week? 🗆 YES 🗆 NO Do you use a seatbelt on a regular basis? 🗆 YES 🗆 NO									
Please list any drugs, medicines, birth you use them?	control (pills, vit	amins, minerals (prescription and nonprescription	or herbal medicines) you use and indicate how often					
Name of drug			Reason for taking drug?	How much are you taking and how often?					
1. 2.									
3.									
4.									
Have you ever experienced adverse re	actions	(hypers	ensitivities, allergies, upset stomach, rash, hives,	etc.) to any of the following? If yes, please explain					
the type of reaction, your age when tr	Yes Yes	on occi. No	irred, and if the experience has occurred more th	an once.					
Penicillin	163	140	EXPIR	anation					
Sulfa									
Other antibiotics (name)									
Asplrin				4.1					
Codeine or other pain relievers									
Other drugs, medicines, chemicals (specify)									
Insect bites									
Food allergies (name)				78.074.774					
Have you ever been a patient in any	Yes	No	Explanation (specify	when, where and why)					
type of hospital?									
Has your academic career been									
interrupted due to physical or emotional problems?		٠							
Have you ever had any serious	1								
illness or Injuries other than those	1								
already noted?									
IMI	PORT	ANT	NFORMATIONPLEASE READ AND	COMPLETE					
Information is strictly confidential and should be ill or injured or otherwise u from my record to a physician, hospit (B) I hereby authorize any medical to	l will not inable to al or oth reatmen	be released by the sign to the sign to the sign the sign the sign to the sign	eased to anyone without my written consent, exce	e providers of the Student Health Center.					
Signature of Student				Date					
The LAW requires that parental perm that medical treatment may be given parent/guardian being contacted and	ission b to the s fully inf	e obtain student formed	who is a minor. However, no major operation wi	r guardian should sign the following consent form so iil be performed except in extreme emergency, without					
(Signed)			(Relationship)	(Date)					
		= 1	Return or fax all information to: Howard University Student Health Center						

Return or fax all Information to: Howard University Student Health Center 2139 Georgia Avenue, NW Washington, D.C. 20059 Phone (202)806-7540 / Fax (202)806-7416



HOWARD UNIVERSITY HEALTH SCIENCES NOTICE OF PRIVACY PRACTICES

Effective Date: April 14, 2003

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.

WHEN THIS NOTICE APPLIES

This notice summarizes the privacy practices of Howard University Hospital and its affiliated clinics, the Howard University Faculty Practice Plan, the Howard University Dental Clinics, the Howard University Student Health Center, and the workforce, medical staff, physicians and health care providers that provide you with treatment and health care services at such locations (collectively referred to as "Howard University Health Sciences"). We may share health information about you with each other for purposes described in this notice, including for our joint administrative activities.

OUR OBLIGATIONS

We are required by law to:

- Maintain the confidentiality of protected health information;
- Give you this notice of our legal duties and privacy practices regarding health information about you; and
- Follow the terms of our notice that are currently in effect.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION

Some kinds of health information also are subject to separate special privacy protections under the laws of the District of Columbia, so that portions of this notice may not apply. If you receive alcohol or substance abuse services or treatment from our substance abuse treatment program, you will receive a separate notice describing how we may use and disclose and protect the privacy of health information regarding your alcohol or substance abuse treatment. If you receive mental health services or treatment, you should contact the Privacy Officer at the address at the end of this Notice to obtain further information on the special protections afforded to this information. In addition, special rules apply to medical records and information relating to acquired immune deficiency syndrome ("AIDS"). The section below entitled "How We May Use and Disclose HIV/AIDS Information" describes how we may use and disclose this type of Health Information.

The following categories of activities describe the ways that we may use and disclose health information that identifies you ("Health Information"). Some of the categories include examples, but not every type of use or disclosure included in a category is listed. Except for the categories of activities described below, we will use and disclose Health Information only with written permission from you. If you give us permission to use or disclose Health Information for a purpose not listed in this notice, you may revoke that permission at any time by sending a written request to our Privacy Officer at the address listed at the end of this notice.

a) For Treatment. We may use Health Information to treat you or provide you with health care services. We may disclose Health Information to doctors, nurses, technicians, or other personnel,

including people outside our facilities or clinics who may be involved in your medical care. For example, we may tell your primary physician about the care we provided you or give Health Information to a specialist to provide you with additional services as appropriate for treatment purposes.

- b) For Payment. We may use and disclose Health Information so that we or others may bill or receive payment from you, from a government program or an insurance company or other responsible third party for the treatment and services you receive. For example, we may give your health plan information about your treatment so that they will pay for such treatment. We also may tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.
- c) For Health Care Operations. We may use and disclose Health Information for health care operations, which are administrative activities involved in running a health care system. These uses and disclosures are necessary to maintain high quality care when delivering services to our patients and for our business and management purposes. For example, we may use Health Information to review the adequacy and quality of the care that our patients receive, and the efficiency of our activities.
- d) Appointment Reminders, Treatment Alternatives, and Health-Related Benefits and Services. We may use and disclose Health Information to contact you as a reminder that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment options or alternatives or health-related benefits and services that may be of interest to you.
- e) Fundraising Activities. We may use Health Information to contact you in an effort to raise money for Howard University Health Sciences. We may disclose Health Information to a related foundation or to our business associates so that they may contact you to raise money for us.
- f) Facility Directory. If you are a Hospital patient, we may list your name and location in our Hospital directory, unless you ask us not to. We may disclose this information to anyone who asks for you by name.
- g) Pastoral Care. We may disclose the information in our facility directory and information that you choose to provide us regarding your religious affiliation to members of the clergy for use and disclosure in their religious activities.
- h) Individuals Involved in Your Care or Payment for Your Care. We may disclose Health Information to a person, such as a family member or friend, who is involved in your medical care or helps pay for your care. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.
- i) Research. Under certain circumstances, we may use and disclose Health Information for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication or treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. This process evaluates a proposed research project and its use of Health Information to balance the benefits of research with the need for privacy of Health Information. We also may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, so long as they do not remove or take a copy of any Health Information.

SPECIAL CIRCUMSTANCES

In addition to the above, we may use and disclose Health Information in the following special circumstances:

 j) As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

- k) To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent or lessen a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, will be to someone who may be able to help prevent the threat.
- Business Associates. We may disclose Health Information to the business associates that we engage to provide services on our behalf if the information is necessary for such services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract with them.
- m) Organ and Tissue Donation. We may release Health Information to organizations that collect statistics on organ donation, and to an organ procurement organization or tissue bank, as necessary to follow through on any steps you already have taken to be an organ or tissue donor.
- n) Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.
- o) Workers' Compensation. We may disclose Health Information as authorized by and to the extent necessary to comply with laws relating to workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.
- p) Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; track certain products and monitor their use and effectiveness; if authorized by law, notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and conduct medical surveillance of our facilities in certain limited circumstances concerning workplace illness or injury. We also may release Health Information to an appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence; however, we will only release this information if you agree or when we are required or authorized by law.
- q) Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure of our facilities and providers. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
- r) Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.
- s) Law Enforcement. We may release Health Information if asked by a law enforcement official as follows: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in emergency circumstances to report a crime, the location of the crime or victims, or the identity, description, or location of the person who committed the crime.
- t) Coroners, Medical Examiners and Funeral Directors. We may release Health Information to a coroner or medical examiner. In some circumstances this may be necessary, for example, to determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

- u) National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.
- v) **Protective Services for the President and Others**. We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.
- w) Inmates or Individuals in Custody. In the case of inmates of a correctional institution or that are under the custody of a law enforcement official, we may release Health Information to the appropriate correctional institution or law enforcement official. This release would be made only if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

HOW WE MAY USE AND DISCLOSE HIV/AIDS INFORMATION

We may use your medical records and information relating to HIV/AIDS so that we can provide you with care, assure payment for our services, and in administrative activities to assure the quality of our care and the safety of our workforce, physicians and other patients. We may disclose this information outside of Howard University Health Sciences only with your written consent, pursuant to a court order, or as required by law.

YOUR RIGHTS

You have the following rights, subject to certain limitations, regarding Health Information we maintain about you:

- a) Right to Inspect and Copy. You have the right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care in accordance with our HIPAA Privacy procedures.
- b) Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is maintained by or for us. You must tell us the reason for your request. We are not required to agree to your amendment.
- c) Right to an Accounting of Disclosures. You have the right to request an accounting of certain disclosures of Health Information we made.
- d) Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. We are not required to agree to your request. You have the right to request a limit on the Health Information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about your surgery with your spouse. If we agree to your request, we will comply with your request unless we need to use the information in certain emergency treatment situations.
- e) Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we contact you only by mail or at work. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.
- f) Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at either of our websites, www.howard.edu or www.huhosp.org.

HOW TO EXERCISE YOUR RIGHTS

Only our Privacy Officer can grant your request to exercise any of your rights described in this Notice. To exercise any of your rights, you must send a request, in writing, to our Privacy Officer:

Attn: Privacy Officer
Office of the Chief Compliance Officer for Health Sciences
Howard University Hospital
2041 Georgia Avenue, N.W., Ste. 2066
Washington, D.C. 20060

You may also email us at Privacy@huhosp.org.

NO OTHER PERSON, STAFF MEMBER, PHYSICIAN, NURSE, OR CLERGY MEMBER IS AUTHORIZED TO GRANT ANY REQUEST TO EXERCISE THE RIGHTS DESCRIBED IN THIS NOTICE.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for Health Information we already have as well as any information we receive in the future. We will post a copy of the current notice at our hospital, clinics and physician offices. The notice will contain the effective date on the first page, in the top right-hand comer.

COMPLAINTS AND QUESTIONS

If you believe your privacy rights have been violated, you may file a complaint with us or the Secretary of the Department of Health and Human Services. To file a complaint with us, contact our Privacy Officer at the address listed above. All complaints must be made in writing. You will not be penalized for filing a complaint.

If you have any questions about this notice, please contact the Health Sciences Privacy Officer at 202.865.5266.