



## Pre-Exposure Prophylaxis Assistance Program Pharmacy User Training Request

This form must be completed by individuals presently working at a certified Office of AIDS (OA) Pre-Exposure and Post-Exposure Prophylaxis Assistance Program (PrEP-AP) contracted pharmacy site and requesting training to become a certified PrEP-AP Pharmacy User. To become a certified PrEP-AP Pharmacy User you must take the PrEP-AP Temporary Coverage Training for Pharmacy Users. Please note that individuals requesting training will not be able to access the ADAP Enrollment System (AES) or process PrEP-AP Temporary Coverage enrollments until they have completed the Pharmacy User certification training and received certification confirmation. Training is conducted via an online platform. Once you have registered, a training invitation and instructions will be sent to you via email within two business days. To receive credit for the training you must complete the on-demand PrEP-AP Temporary Coverage for Pharmacy Users course and return your certificate of completion to [ADAP.Training@cdph.ca.gov](mailto:ADAP.Training@cdph.ca.gov).

Please submit a completed copy of the Pharmacy User Training Request Form and Oath of Confidentiality to [ADAP.Training@cdph.ca.gov](mailto:ADAP.Training@cdph.ca.gov). Please make sure to complete **all sections** of the form. Incomplete or illegible forms will be returned and may effect timely registration.

\_\_\_\_\_  
(Print First and Last Name)

\_\_\_\_\_  
(Month and Day of Birth (MM/DD))

\_\_\_\_\_  
(Pharmacy User Telephone Number)

\_\_\_\_\_  
(Contracted Pharmacy Site Fax)

\_\_\_\_\_  
(Pharmacy User Email)

\_\_\_\_\_  
(Pharmacy Site Name and Assigned Pharmacy Site Number)

Are you working at more than one site?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please list the additional pharmacy enrollment site name(s) and number(s):

\_\_\_\_\_

\_\_\_\_\_



\_\_\_\_\_  
(Pharmacy User Signature)

\_\_\_\_\_  
(Date)

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**Contracted Pharmacy Site Supervisor Signature:**

\_\_\_\_\_  
Contracted Pharmacy Site Name/Number

\_\_\_\_\_  
Site Contact/Supervisor Name

\_\_\_\_\_  
Site Contact/Supervisor Telephone Number

\_\_\_\_\_  
Site Contact/Supervisor Signature



## **Agreement by Employee/Contractor To Comply with Confidentiality Requirements**

### **Summary of Statutes Pertaining to Confidential Public Health Records and Penalties for Disclosure**

All HIV/AIDS case reports and any information collected or maintained in the course of surveillance-related activities that may directly or indirectly identify an individual are considered confidential public health record(s) under California Health and Safety Code (HSC), Section 121035(c) and must be handled with the utmost confidentiality. Furthermore, HSC §121025(a) prohibits the disclosure of HIV/AIDS-related public health records that contain any personally identifying information to any third party, unless authorized by law for public health purposes, or by the written consent of the individual identified in the record or his/her guardian/conservator. Except as permitted by law, any person who negligently discloses information contained in a confidential public health record to a third party is subject to a civil penalty of up to \$5,000 plus court costs, as provided in HSC §121025(e)(1). Any person who willfully or maliciously discloses the content of a public health record, except as authorized by law, is subject to a civil penalty of \$5,000-\$25,000 plus court costs as provided by HSC §121025(e)(2). Any willful, malicious, or negligent disclosure of information contained in a public health record in violation of state law that results in economic, bodily, or psychological harm to the person named in the record is a misdemeanor, punishable by imprisonment for a period of up to one year and/or a fine of up to \$25,000 plus court costs (HSC §121025(e)(3)). Any person who is guilty of a confidentiality infringement of the foregoing type may be sued by the injured party and shall be personally liable for all actual damages incurred for economic, bodily, or psychological harm as a result of the breach (HSC §121025(e)(4)). Each disclosure in violation of California law is a separate, actionable offense (HSC §121025(e)(5)).

Because an assurance of case confidentiality is the foremost concern of the California Department of Public Health, Office of AIDS (CDPH/OA), any actual or potential breach of confidentiality shall be immediately reported. In the event of any suspected breach, staff shall immediately notify the director or supervisor of the local health department's HIV/AIDS surveillance unit who in turn shall notify the CDPH/OA Surveillance Section Chief or designee. CDPH/OA, in conjunction with the local health department and the local health officer shall promptly investigate the suspected breach. Any evidence of an actual breach shall be reported to the law enforcement agency that has jurisdiction.

### **Employee Confidentiality Pledge**

I recognize that in carrying out my assigned duties, I may obtain access to private information about persons diagnosed with HIV or AIDS that was provided under an assurance of confidentiality. I understand that I am prohibited from disclosing or otherwise releasing any personally identifying information, either directly or indirectly, about any individual named in any HIV/AIDS confidential public health record. Should I be



responsible for any breach of confidentiality, I understand that civil and/or criminal penalties may be brought against me. I acknowledge that my responsibility to ensure the privacy of protected health information contained in any electronic records, paper documents, or verbal communications to which I may gain access shall not expire, even after my employment or affiliation with the Department has terminated.

By my signature, I acknowledge that I have read, understand, and agree to comply with the terms and conditions above.

\_\_\_\_\_  
(Print Pharmacy User Name)

\_\_\_\_\_  
(Pharmacy User Signature)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Print Contracted Site Contact/Supervisor Name)

\_\_\_\_\_  
(Site Contact/Supervisor Signature)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Name of Employer)

PLEASE RETAIN A COPY OF THIS DOCUMENT FOR YOUR RECORDS