



SCDC POLICY

This policy has been developed in response to and as a portion of the Remedial Plan agreed upon by the parties in the settlement of T.R. V. South Carolina Department of Corrections, No. 2005-CP-40-02925. As agreed by the parties in the Settlement Agreement, it is the understanding and agreement of the parties that implementation and effectuation of the provisions of this policy as a portion of the Remedial Plan shall be phased in over time and all aspects shall not become effective immediately. (See Section 2 - Summary of Agreement and Section 4 (f) - Implementation Phase-In of Settlement Agreement effective May 2, 2016).

NUMBER: HS-19.14

TITLE: MENTAL HEALTH SERVICES - INMATE HEALTH RECORDS GENERAL GUIDELINES

ISSUE DATE: August 31, 2016

RESPONSIBLE AUTHORITY: DIVISION OF MENTAL HEALTH SERVICES

OPERATIONS MANUAL: HEALTH SERVICES

SUPERSEDES: SCDC POLICY HS-19.02 (dated July 1, 2008) - NEW POLICY

RELEVANT SCDC FORMS/SUPPLIES: 19-11, 20-67, 26-40, M-6, M-10, M-13, M-14 , M-16, M-17, M-20, M-30, M-38, M-41, M-42, M-43, M-45, M-52, M-53, M-55, M-57, M-62, M-65, M-71, M-74, M-76, M-79, M-80, M-84, M-88, M-99, M-100, M-103, M-108, M-109, M-110, M-112, M-113, M-116, M-119, M-120, M-121, M-122, M-123, M-152, M-155

ACA STANDARDS: 4-ACRS-2A-09, 4-ACRS-4C-13, 4-ACRS-4C-22, 4-ACRS-4C-23, 4-ACRS-4C-24, 4-ACRS-7D-08, 4-ACRS-7D-10, 4-4095, 4-4098, 4-4099, 4-4350, 4-4362, 4-4365, 4-4366, 4-4396

STATE/FEDERAL STATUTES: SC Code Ann. § 24-1-130; SC Code Ann. § 44-115-10 through 150; SC Code Ann. § 44-22-10 through 220; HIPPA; Pub.L. 104-191, 110 Stat. 1936; C.F.R. § T. 42, Ch. I, Subch. A, Pt. 2; 42 U.S.C.A. § 12101; SC Code Ann. § 44-17-810 through 900

PURPOSE: To promote consistency and accuracy when documenting in and securing an inmate's medical record. A health record shall be maintained for each inmate under the custody of SCDC. This record shall contain accurate, cumulative documentation of all healthcare services and encounters provided throughout the period of incarceration. There shall be an automated medical record as well as a hard copy medical record.

POLICY STATEMENT: The Agency is committed to upholding the confidentiality and privacy of an inmate's medical history. Therefore, an inmate's medical history/record will be accessible to authorized South Carolina Department of Corrections (SCDC) personnel and others for duly authorized purposes only in accordance with applicable Agency policies, and state and federal statutes.

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SPECIFIC PROCEDURES:

1. GENERAL PROVISIONS:

1.1 The Deputy Director of Health Services will appoint an interdisciplinary group of Healthcare professionals to a Documentation Standards Committee. This committee is made up of the Director of Nursing, the Regional Nurse Coordinators, the Director of Health Information Records, the Medical Director, the Chief Psychiatrist, the Director of Pharmacy, the Director of Laboratory Services, and the Assistant Deputy Director. This committee will be tasked with developing guidelines for documenting information in an inmate's medical record. The Documentation Standards Committee will be chaired by the Director of Health Information Records, and will be responsible for developing and updating guidelines for medical documentation and compiling the health record.

1.2 The inmate's complete health record may consist of the medical hard chart, the Infirmary hard chart, the Gilliam Psychiatric Hospital (GPH) hard chart, and the automated medical record (AMR), and shall accompany the inmate upon each transfer to another SCDC facility.

1.3 The health record may never be removed from the facility where the inmate is housed for healthcare purposes. If an outside treatment facility requires information from the medical record for care, then copies of the information required are made and sent with the inmate to the provider conducting the offsite care/treatment.

1.4 When an inmate is released to post incarceration supervision, all healthcare records shall be forwarded, with case management records, to Health Information Resources central office for storage, retention, and disposition.

2. PROCEDURES:

2.1 Establishment of the Health Record:

2.1.1 The medical staff at Kirkland R & E Center shall be responsible for initiating a hard chart health record at the time of the inmate's reception into SCDC custody. Additional hard charts are created when an inmate is admitted to an SCDC Infirmary or SCDC's Gilliam Psychiatric Hospital (GPH). The automated chart is created through security staff once the inmate is issued an SCDC number.

2.13.2 The Administrative Specialist/Certified Nursing Assistant (CNA) or nursing staff at each institution will be responsible for maintaining the medical records and medical records area at each facility. All health records for each incarceration shall be brought forward and filed under the inmate's current assigned SCDC number. However, psychological raw test data will be housed separately with the Chief Psychologist.

2.2 Contents of the Medical/Infirmary/GPH/AMR File: The hard chart health record shall be established and maintained according to standards set forth in Health Services Procedures (HSP) 3000.5. The final organization of the chart is as follows:

Section I - (Interfile in Reverse Chronological Order):

- *** DO NOT RESUSCITATE (DHEC Form #3462)
- M-30 Information for Released Inmate (yellow copy)

M-110	Medical Clearance for Institutional Transfer
M-16	Sick Call Clinic Notes
M-45	Discharge Information
M-52	Neurological Exam Record
M-74	Physical Assessment of Suspected Chemical User
M-38	SCDC Emergency Room Record (for inmates not admitted to the hospital or infirmary)

Section II - PROBLEMS, MEDS, INPATIENT (Group File in Reverse Chronological Order):

M-116	Appointment/Information Card (may be discarded when full)
M-76	Problem List
M-123	Health Summary for Classification/Assignment
24-155	HIV Patient Education and Counseling Record
M-113	Chronic Infectious Disease Monitor
M-112	Data Collection for Persons with Positive HIV Tests
M-88	Medication Profile
M-10	Daily Medication Administration Record
M-41	Diabetic Care Record
M-103	Cardiovascular Follow-up Record
M-119	Evaluation for Active TB
M-99	Tuberculosis Preventive Treatment Record
M-100	Tuberculosis Treatment Record

*** All inpatient records with newest admission on top. This includes SCDC infirmary records and inpatient records from hospitalizations that were generated while the inmate was incarcerated. This does not include old outside hospital records from before incarcerations.

Section III - DENTAL CLINIC, MENTAL HEALTH:

DENTAL	(Interfile in Reverse Chronological Order)
M-19 (A and B)	Dental Health Records
***	(Panorex, other Dental X-rays, Old Dental Card in Pocket)
M-38	Dental Statement of Responsibility
MENTAL HEALTH	(Interfile in Reverse Chronological Order.) This record will include all entries documenting mental health services.
M-122	Referral/Action Taken Form
M-121	Request for Behavioral Medicine Services
26-40	Initial Interview (Data Sheet.) This form is now computerized, but may still be found in older records.
***	Gilliam Psychiatric Hospital Discharge Summaries (Copy only. Original will be in the GPH 2 record.)
***	Psychological Evaluations
***	ICS (ICU) Forms

***	All other mental health information M-107 Consent for Neuroleptic Medication
M-108	Consent or Denial of Consent to Use Neuroleptic Medication in Patients with Tardive Dyskinesia
M-120	Mental Health Observation
M-65	Consent for Gilliam Psychiatric Hospital Treatment Copies of SCDMH forms for Admission to GPH
***	GBMI Court Order
M-16	Sick Call Clinic Notes (for mental health progress notes only)

Section IV - LAB, RADIOLOGY, EKG:

LAB	(Interfile laboratory reports in reverse chronological order. This may include the old M-20, M-57, M-71, M-80, M-84 forms that are no longer in use.) (NOTE: If the laboratory returns a requisition with "RECOLLECT" written on it, that lab requisition must be filed as any other lab slip as part of the permanent medical record.)
RADIOLOGY	(Interfile in Reverse Chronological Order.)
M-55	X-ray Requisition and Report (NOTE: remove temporary fax! photocopy of report when original is filed.)
***	Radiology, ultrasound, CT, MM, etc., reports from community resources.
EKG	EKGs (NOTE: If the EKG is on thermal paper, make a copy and file the photocopy only. Thermal paper reports fade with age.)

Section V - CONSULTS, CORRESPONDENCE, MISCELLANEOUS (Interfile in reverse chronological order):

M-7 (A and B)	Physician's Transfer Note or Consultation
M-122	Referral/Action Taken form (only if used for non-mental health referrals)
M-62	Analytical Eye Record
***	Dictated notes from community physicians, healthcare providers
M-42	Outside Elective Healthcare Request
M-79	Request for Special Housing for Physically Disabled Inmates
***	Letters/memos sent or received with pertinent medical information, other miscellaneous correspondence (NOTE: No CRT messages, e-mails, grievances, billing authorizations, security clearances, etc.)
M-43	Authorization for Procedure and/or Administration of Anesthesia
9-11	Inmate/Resident Release of Information Consent
M-53	Refusal of Medical Advice Form
***	Approval for Prosthesis and Release of Liability for SCDC
20-67	Dietitian Visitation Report

M-13 Release of Medical Information to SCDC (yellow copy)
(NOTE: When the community records are received, they should be stapled to SCDC Form M-13, if not already sent with a copy. Be sure to file these by the date of the contents, not the date the record is requested or received. These will normally be on the bottom of this section, as their dates will be normally prior to incarceration.)

Section VI - PERSONAL DATA (Group File in Reverse Chronological Order):

M-109 Periodic Physical Assessment (old form, used only if AMR unavailable)
M-17 (A and B) R&E Centers Medical Examination (used only if AMR unavailable)
M-14 Medical Screen
M-6 Health Related Supplies

2.3 The Infirmary hard chart record shall be established and maintained according to standards set forth in Health Services Procedures (HSP) 3000.6. This record will be maintained as a separate record while an inmate is in the Infirmary.

2.3.1 SECTION I (top to bottom):

- Discharge Summary;
- Patient Information Sheet (H&P); and
- Consultations (group filed in reverse chronological order).

2.3.2 SECTION II:

- Physician's Progress Notes (group filed in reverse chronological order);
- Physician's Orders (group filed in reverse chronological order); and
- Inmate Refusals (group filed in reverse chronological order).

2.3.3 SECTION III:

- Lab (group filed or interfiled in reverse chronological order);
- X-rays (group filed or interfiled in reverse chronological order);
- EKGs (group filed or interfiled in reverse chronological order); and
- Scans, etc. (group filed or interfiled in reverse chronological order).

2.3.4 SECTION IV:

- MARS (in reverse chronological order).

2.3.5 SECTION V:

- Graphics (group filed in reverse chronological order);
- The GPH hard chart record shall be rust colored with six (6) sections, as are the health and Infirmary charts. However, the forms used during each hospital stay will be filed together in each section.

- The Automated Medical Record (AMR) is divided into five (5) main sections: Section I: Initial Physical Examination F2; Section II: Prescription Medications F5; Section III: Chronological Healthcare Encounters F3; Section IV: Allergies F8; and Section V: Vaccinations F6.
- Only healthcare personnel shall have input, when appropriate, into the medical files. Each entry documented within the health record shall contain a printed name, title, date, and signature of the healthcare staff member entering the information.

3. HEALTH RECORD MAINTENANCE AND REVIEW:

3.1 The Nursing Supervisor of the facility in which the inmate is housed shall ensure that each health record is maintained consistent with SCDC policy to ensure that charts:

- Serve as a basis for planning individual care;
- Facilitate continuity of evaluation, treatment, and any changes in condition;
- Facilitate evaluation of care;
- Protect the legal interests of SCDC;
- Serve as a basis for statistical analysis and clinical data for use in program planning, education, and approved research; and
- Facilitate communication between the responsible physician and other healthcare providers.

3.2 The Health Information Records Director shall conduct **quarterly audits** of health records at each facility. This audit shall be for the purpose of ensuring accuracy and completeness of information, organizational conformity, and storage security.

4. PRIVACY AND CONFIDENTIALITY OF MEDICAL/HEALTH RECORDS:

4.1 The health record is confidential, and will be maintained separately from the confinement record.

- Access to health records should be safeguarded by the medical staff;
- Records rooms are to be locked when medical staff are not present; and
- Records, whether hard copy or electronic, are not to be left accessible to inmates or non-medical staff members.

4.2 Each employee who has access to protected health information will keep such information confidential. Employees who fail to follow the Agency's standards for protecting the security and confidentiality of protected health information will be subject to corrective action as outlined in SCDC Policy ADM-11.04, "Employee Corrective Action."

4.3 The Division of Resource and Information Management (RIM) will ensure that employees are only given access to the AMR when approval is provided through the on-line Access Requests System.

4.4 Statutory authority of confidentiality of drug abuse patient record must fall within applicable federal laws (42 CFR Part 2). Records of the identity, diagnosis, or treatment of any patient which are maintained in connection with performance of any drug treatment program shall be confidential and be disclosed only for the purposes and under the circumstances outlined below:

- Written consent from the patient;
- Medical personnel to the extent necessary to meet a bona fide medical emergency; and
- To qualified personnel for the purpose of conducting scientific research, management audits, financial audits, or program evaluation. Such information may not identify, directly or indirectly, any individual

patient in any report of such research, audit, or evaluation, or otherwise disclose patient identities in any manner.

4.5 There is a prohibition against use of a health record in making criminal charges or investigation of a patient. Except as authorized by a court order, no record may be used to initiate or substantiate any criminal charges against a patient or to conduct any investigation of a patient.

4.6 SCDC will protect the privacy of an individual's Protective Health Information in accordance with HIPPA and other federal and state statutes regarding privacy.

4.7 Uses and Disclosures of HIV/AIDS Information: HIV/AIDS records may be disclosed to another healthcare provider for treatment purposes only when SCDC has provided direct medical care to the individual and refers the person to or consults with the healthcare provider to whom the information is released. **Test results are confidential.** Under state statute, confidential HIV/AIDS information can only be given to people whom the person in lawful custody allows to have it by providing written authorization, or to people who need to know the person's HIV status in order to provide medical care and services. The law allows HIV information to be released under limited circumstances by special court order and to public health officials as required by law.

5. RELEASE OF INFORMATION:

5.1 The request to release information is sent to Health Information Records to ensure that any health record information is released in a manner consistent with statutory requirements and accepted standards of care and security.

- Protected health information may only be released to individuals, other than the inmate, by the Director of Health Information Resources (HIR) or designee, with the inmate's written permission or pursuant to a court order.
- An administrative fee, determined by HIR, will be charged for copies of a health record as specified in HSP 2000.1.
- Copies of health records will be provided at no charge to a physician or healthcare provider for continuation of treatment for a specific condition or conditions.

5.2 Information will be released upon receipt of a properly executed court order or subpoena. All court orders or subpoenas for inmate health records by any of the institutions should be forwarded immediately to HIR for processing within twenty-four (24) hours of receipt or notification. Information will be released to the General Counsel's Office (or designee) upon request.

5.3 The Nursing Supervisor (NS)/designee will be permitted to share information with the appropriate correctional authorities on a need to know basis as it pertains to: an inmate's medical management, security, or his/her ability to participate in programs. If a non-medical staff member is given medical information about an inmate because of a particular need to know, e.g., post-exposure care, transportation, grievance, investigation, etc., that staff member must uphold the confidentiality of that medical information. (Refer to Health Services Procedure (HSP) 2000.3, "Internal Affairs Access to Health Records".)

5.4 Information regarding communicable diseases may be released by the Director of Laboratory Services, HIR, or NS/designee to county health departments or to DHEC in accordance with state and federal laws.

5.5 When an inmate is referred to healthcare providers outside of SCDC, appropriate health information will be shared with those providers in accordance with HIPPA laws.

5.6 Information will be released to designated parties or agencies with a legitimate need for information (e.g., the inmate's attorney, a physician, including an elective outside medical care physician, a medical facility in the community, the Vocational Rehabilitation Department, or the Social Security Administration) by the Central HIR staff when the inmate provides his/her consent on SCDC Form 9-11, "Inmate/Resident Release of Information Consent," or a consent form provided by that agency or designated party.

5.7 When faxing or mailing protected health information to attorneys, outside physician's offices, etc., a cover sheet must be used. All electronic communication containing protected information must be sent encrypted.

5.8 SCDC medical clinics will offer inmates SCDC Form M-152, "Consent to Release Medical Information," so that an inmate may designate a family member or other person to whom medical information may be shared. When an inmate's family member or other individual contacts SCDC staff with questions or concerns regarding health care issues, protected health information will only be shared if a consent form has been signed by the inmate allowing disclosure to that individual.

6. AN INMATE'S ACCESS TO HIS/HER OWN MEDICAL RECORD (see HSP 2000.1):

6.1 An inmate's medical record belongs to SCDC, but the information contained in the record may be made available to that inmate in accordance with the following guidelines: (See Health Services Procedure 2000.1, "Inmate Access to his/her Health Record," for specific guidelines.)

6.2 An inmate may make an appointment (using SCDC Form 19-11, "Request to Staff Member") with medical staff to review his/her health record and may take notes in the presence of this staff member.

- The inmate may view encounters in the automated medical record (AMR) in the presence of a medical staff member at the discretion of that staff member. (This will exclude mental health information unless permission is given by the Chief Psychiatrist or designee--see paragraph 4.2 below.)

6.3 An inmate may request to review portions of his/her psychiatric or psychological records using SCDC Form 19-11, "Request to Staff Member." These requests will be evaluated by the Chief of Psychiatry or designee before the inmate will be given an appointment to review the record in the presence of a mental health professional.

6.4 An inmate may request a single copy of his/her HIV report and/or Analytical Eye Record using SCDC Form 19-11, "Request to Staff Member." A copy will be made by the medical staff, who will note in the AMR that the inmate was given a copy of the HIV report and/or Analytical Eye Record.

6.5 An inmate may request copies of his/her health record or portions thereof on SCDC Form 19-11, "Request to Staff Member." Each request will be forwarded to the Director HIR or designee for evaluation on a case-by-case basis. Once the request is received, the inmate will be sent an MR-1 form agreeing to the cost of records. If copies are made, the inmate will be charged a fee in accordance with HSP 2000.1, "Inmate Access to his/her Health Record."

7. REQUESTING INFORMATION FROM OUTSIDE PROVIDERS (see HSP 2000.5):

7.1 When an SCDC physician requires copies of an inmate's non-SCDC medical records, Health Services staff will have the inmate sign SCDC Supply M-13, "Release of Medical Information to the South Carolina Department of Corrections," and fax that signed form to the outside facility's records office in order to obtain the records. (Refer to Health Services Procedures 2000.5, "Requesting Medical Information from Outside Providers," for further details.)

8. TRANSFER OF HEALTH RECORDS (see HSP 2000.6):

8.1 The inmate's health record will be transferred with him/her when s/he is transferred from one area of medical coverage to another, to ensure continuity of care.

8.2 When permanent hard copies of medical records are transferred from one institution to another, appropriate AMR entries will be made by both the sending and receiving institutional medical staff. The hard copy of the record will be transported in a SEALED envelope labeled 'CONFIDENTIAL.' (Refer to Health Services Procedure 2000.6, "Transfer of Medical Records," for further details.)

8.3 If an inmate is transferred to a community facility (physician appointment, outpatient procedure, emergency room, or hospital admission), the medical record will stay at the inmate's assigned institution. *Only pertinent copies may accompany the inmate. After the appointment, procedure, or admission, if the inmate is returned to a different SCDC facility/infirmiry, the original record will be forwarded to that facility/infirmiry.*

8.4 When an inmate is transferred for emergency care within the Agency, the hard copy of the medical record will initially remain at the inmate's assigned institution. The SCDC ER medical staff will document his/her care in the AMR. If the inmate is admitted to the infirmiry, the infirmiry staff will request the hard copy of the medical record from the sending institution (may be the next working day, as appropriate).

8.5 If an inmate is admitted to an SCDC infirmiry, the charge nurse or designee will send the medical record to the infirmiry. The health record will accompany the inmate when s/he is discharged from the SCDC infirmiry to return to his/her assigned institution.

8.6 If an inmate transfers for a court hearing, the medical staff will review the record and send pertinent copies (e.g., Problem List, Medication Administration Record, etc.), as applicable, along with the inmate's medication. The original medical record will remain at the inmate's assigned institution.

9. INMATE DEATH (see HSP 200.4):

9.1 If an inmate death occurs, the nurse or designee will notify the Central HIR office according to procedures outlined in HSP 200.4, "Inmate Death."

9.2 The medical staff will forward all appropriate volumes of the inmate's medical record, including the sick call notes documenting the incident, the current infirmiry record, and the GPH record, if applicable, to the contracting pathologist, as outlined in HSP 2000.6, "Transfer of Medical Record." Central HIR staff will be responsible for retrieving the record from the pathologist.

9.3 If an autopsy is not required, the inmate's complete medical record (including all medical, infirmiry, and GPH volumes) will be sent to the central HIR office by the institutional medical staff where the death occurred.

10. ESCAPE: In the event of an inmate escape, the medical record will be held in the inmate's assigned institution for five (5) days. If the inmate has not been apprehended after this time, his/her medical record will be sent to the central HIR office.

11. RELEASE: When an inmate is released, the medical record will be sent to the central HIR office.

12. INACTIVE HEALTH RECORDS:

12.1 Inactive health records will be maintained by the central HIR office in hard copy form according to the Agency's Retention Schedule.

12.2 If an inmate re-enters SCDC, the R&E medical records staff will be sent the old health record from central HIR to combine the old and new record.

13. QUALITY MANAGEMENT: Annually and as needed, the Director of HIR or designee will conduct audits of 10% of the health records at each institution. In addition, the storage site will be audited for maintenance and security. A report of these audits will be distributed to the Documentation Standards Committee members.

14. DEFINITION(S):

Contract Medical Consultant refers to the physician, dentist, or the nurse hired under contract to SCDC to provide or assist with medical treatment.

Deputy Director of Health Services refers to the position assigned to the Health Services Division responsible for the coordination of medical and mental health service delivery to inmates.

Director of Health Records refers to an individual with a minimum of a BA in Health Information Management or a certified medical records administrator who is responsible for the management of health records including mental health records throughout the SCDC system. He/she is also responsible for training and supervision of medical record administrators at the institutional level.

Documentation Standards Committee refers to an interdisciplinary group of health professionals who will determine guidelines for documenting information in the medical/health record. The Committee will be responsible for approving standard abbreviations, documentation format (e.g., D.A.P., S.O.A.P.), structural documentation guidelines (e.g., black ink, yellow highlighters, proper error correction, etc.), new and revised forms, and required content to meet professional and legal standards. This Committee will be appointed by the Deputy Director of Health Services.

Facility Records Office refers to the secure office where current medical records are kept.

Health Information Central Office Manager refers to the position assigned to the Health Services Division responsible for the storage of the medical and mental health records for inmates who are released or discharged to probation or assigned to a designated facility.

Health Insurance Portability and Accountability Act or HIPPA refers to a U.S. law designed to provide privacy standards to protect patients' healthcare records and other health information provided to health plans, doctors, hospitals, and other healthcare providers. Developed by the Department of Health and Human Services, these standards provide patients with access to their healthcare records and more control over how their personal health information is used and disclosed.

Health Record refers to medical and mental health information maintained and secured by the healthcare provider and contained in the form of electronic or paper media.

Inactive Health Record refers to medical, dental, and mental health records of all inmates discharged from their sentence or released to post-incarceration supervision. The records are sent to HIR thirty (30) days after their release to be held until they are disposed of or the inmates are re-incarcerated. Whenever a former inmate returns to SCDC custody, the health record is then sent to Kirkland R&E or Camille Graham R&E, as appropriate.

Inactive Offender Records Repository refers to a centralized inactive records section for SCDC.

Medical Director - refers to the person in the Agency who is responsible for the provision of healthcare for SCDC.

Medical/Health Record/Automated Medical Record (AMR) refers to health information and medical forms (automated or hard copy) maintained by the Agency on each inmate admitted to SCDC. The terms "health record," "medical record," and "AMR" are used interchangeably throughout this policy and related procedures.

Medical/Mental Health File reflects all medical, dental, and mental health initial assessment orders and treatments provided, including consultations and X-ray films.

Mental Health File refers to the raw psychological testing data file. It reflects all mental health and psychiatric testing material.

Medical Record Administrative Support Person refers to a staff member at the institutional level responsible for the management of health records/mental health records.

Nursing Supervisor refers to the nurse responsible for the provision of healthcare services at a facility.

Protected Health Information refers to all individually identifiable health information transmitted or maintained by a covered entity, hybrid entity, or business associate, regardless of form.

Transfer refers to, for the purposes of this policy, an inmate and/or his/her health record moving from one area of medical coverage to another, whether it be temporary (inpatient infirmary stay, court appearance, etc.) or permanent (reassignment to another institution).

SIGNATURE ON FILE

s/Bryan P. Stirling, Director

Date of Signature

ORIGINAL SIGNED COPY MAINTAINED IN THE OFFICE OF POLICY DEVELOPMENT.