GUIDE TO POLICIES OF CREIGHTON UNIVERSITY

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UNIVERSITY ORGANIZATIONAL CHART
This Guide to Policies of Creighton University is intended to assist the Creighton community to locate information concerning University Policies and other policies throughout the University.

Copies of this Guide are located in the offices of the President, Vice Presidents, Deans, Directors of the University named on the University Organizational Chart in this Guide, and in the three libraries of the University: Reinert Alumni Memorial Library, Health Sciences Library, and Law Library. This Guide replaces the former University Policies Manual and should be located in a place easily accessible for use by faculty, staff, and administrators in your area.

The responsibility for producing this Guide rests with the Office of the President. It is the responsibility of the Vice Presidents, Deans, and Directors to keep this Guide current. When University Policies are developed or revised, the holders of the Guide will receive the entire policy to be included in their binders.

The "Introduction" to this Guide has information concerning how University Policies are proposed, approved, and promulgated. When new University Policies are written and submitted for the President's approval, they should be written according to the format described on pages five and six of the "Introduction."

If you have any questions concerning University Policies, contact the President's Office. If you have any questions concerning other policies cited throughout this Guide, contact the office or person referenced on the Creighton University Organizational Chart.

President's Office
July 1, 2000
GUIDE TO POLICIES OF CREIGHTON UNIVERSITY

INTRODUCTION

I. NEED FOR GUIDE TO POLICIES OF CREIGHTON UNIVERSITY

Policies for Creighton University have existed since the first day classes were held on September 2, 1878. The University opened its doors with four Jesuits, one lay man and a lay woman as the first faculty members. Over the years the Creighton community has organized itself and made policies and procedures to fit the needs of the time. Today the volume of information concerning policies and procedures for managing the multiple areas of the University needs to be organized so faculty, administrators, and staff have the proper information to do their best work. When an employee asks, "Do we have a policy on ...?" this Guide should facilitate finding the information that is needed.

The Guide to Policies of Creighton University is intended to be a quick reference to information throughout the University. This Guide is distributed to Vice Presidents, Deans, Directors named on the Organizational Chart in this book, and to the three libraries of the University. Additionally, the Guide is available on-line at the following website address: http://www.creighton.edu/office-of-the-president/organization. The University reserves the right to modify, amend, or terminate policies in this Guide at any time. The policies do not constitute a contract between the University and the faculty/employee.

It is the responsibility of the General Counsel to keep this Guide current. The General Counsel’s Office should be notified when information contained in this Guide is being revised.

II. SCOPE OF POLICIES IN THIS GUIDE

It is not the intent that this Guide include all the policies and procedures of Creighton University. It is a reference to find information concerning policies. The Organizational Chart of the University, at the end of this Guide, has names of persons to contact for detailed information.

This Guide has these sections:

♦ Creighton University Policies
♦ Creighton University Statutes (website referenced)
♦ Creighton University Faculty Handbook (website referenced)
♦ Creighton University Employee Handbook (website referenced)
♦ Creighton University Student Handbook (website referenced)
♦ Creighton University Manuals (Indexes or website addresses of these manuals are referenced.)
  ◊ Affirmative Action Plan
  ◊ Budget Office Policies and Procedures Manual
  ◊ Accounting Services Policies and Procedures Manual
  ◊ Graphic Standards Manual
  ◊ Purchasing Policies and Procedures Manual
♦ Creighton University Organizational Chart
Creighton University Policies (http://www.creighton.edu/office-of-the-president/organization)

University policies are those that have been approved by the President and the Vice Presidents of the University.

University policies have been formulated throughout the history of the University. The policies address a broad spectrum of topics. In this Guide the University policies are divided according to Identity, Administration (General, Human Resources, Facilities), Financial, and Academic Concerns (Faculty, Students).

Other sections may be added in the future if the need arises.

Creighton University Statutes (http://www.creighton.edu/office-of-the-president/organization)

The Creighton University Statutes are promulgated by the General Counsel’s office of Creighton University. The Statutes govern the daily operations of the University under the authority of the President and Board of Trustees, as provided by the Articles of Incorporation, the laws of the State of Nebraska, and the Bylaws of Creighton University, as adopted by the Board of Trustees.

Amendments to the Creighton University Statutes are approved by the Academic Council and forwarded to the President for his approval. The Creighton University Statutes are revised as needed.

Creighton University Faculty Handbook (http://www.creighton.edu/office-of-the-president/organization)

The Creighton University Faculty Handbook governs the definition and organization of the University faculty and the relationship between the University and the faculty. It defines procedures for faculty appointment, promotion, tenure, non-reappointment, termination and dismissal, establishes grievance procedures, and establishes procedures to protect Academic Freedom. The Faculty Handbook defines faculty responsibilities, duties, conduct, benefits, services, and organizations. It also provides information of interest to faculty members.

Amendments to the Faculty Handbook are approved by the Academic Council and forwarded to the President for his approval. The Faculty Handbook is revised annually by the General Counsel’s office.

Creighton University Employee Handbook (http://www.creighton.edu/hr/toolbox/handbooken/index.php)

The Creighton University Employee Handbook provides general information to staff about the University. It includes particular information for exempt and non-exempt employees as well as benefits for all employees. The handbook is not an employment contract.

The Director of Human Resources oversees the contents of the Creighton University Employee Handbook.
**Creighton University Student Handbook**

(http://www.creighton.edu/students/aboutstudentlife/studenthandbook/index.php)

The *Creighton University Student Handbook* is the official guide for all students of the University. Every student is held responsible for knowledge of the regulations and information contained in the handbook. The handbook contains information about student services, academic regulations, University resources, student organizations and activities, the code of conduct, and various University regulations that pertain to students. The Residence Life policies are a special section of the *Student Handbook*. The Vice President for Student Life oversees the contents of the *Student Handbook*.

**Creighton University Manuals**

Some offices of the University have distributed manuals containing the policies and procedures of a specific office. The Table of Contents and the offices to be contacted are referenced in this Guide.

◊ **Affirmative Action Plan**

The *Affirmative Action Plan* is written in accordance with the applicable Federal Laws and Regulations. The employment policies and practices of Creighton University are administered without unlawful regard to race, color, religion, national origin, sex, age, disability, marital status, or veteran status. The *Affirmative Action Plan* describes Creighton University's status and progress concerning the Plan.

The Director of Affirmative Action prepares the plan for the President's approval and signature. The Affirmative Action Plan is distributed by the President's Office to Vice Presidents, Deans, and appropriate Directors.

◊ **Accounting Services Policies and Procedures Manual**

(http://www.creighton.edu/finance/sharedservices/home/index.php)

Accounting Services has developed the Policies and Procedures Manual to assist all departments in understanding University fiscal policies, expediting their financial transaction processing, and to share information regarding the department’s mission and roles.

◊ **Graphic Standards Manual**

(http://logo.creighton.edu/)

The *Graphic Standards Manual* is designed to define the manner in which Creighton University is to be visually identified to its various publics. The Public Relations Office is responsible for this manual.
The Purchasing Policies and Procedures Manual is designed to provide a brief overview of the Purchasing function as it relates to the University. The Purchasing Department is responsible for this manual.

Creighton University Organizational Chart

The Creighton University Organizational Chart is revised periodically. The President, Vice Presidents, Deans, Directors, and other administrators of the University are identified. This chart is referenced throughout this Guide for persons to contact for more detailed information. The President's Office is responsible for the development of this chart.

III. POLICIES OF COLLEGES AND SCHOOLS

The colleges and schools of Creighton University have policies that are specific to the organization and management of a particular college or school.

The academic administrative units of the University are the following:

- College of Arts and Sciences
- College of Business
- Graduate School, University College and Summer Sessions
- School of Dentistry
- School of Law
- School of Medicine
- School of Nursing
- School of Pharmacy and Health Professions

The colleges and schools have Bylaws which govern the internal administration of the particular school/college. The Bylaws are written in compliance with the Creighton University Statutes.

The colleges and schools have Executive Committees to advise the Deans concerning matters which relate to the internal academic affairs of the individual colleges and schools.

The policies and procedures of a particular college or school are found in the Bylaws and respective bulletins of the colleges and schools.

IV. OFFICES WITHIN VICE PRESIDENTIAL AREAS

Offices of Vice Presidential areas are named on the Organizational Chart in this Guide. The policies and procedures of those offices address the internal management of a particular office and may address general policies that affect other areas of the University. For more information about the policies of a particular office, consult the Director of the office referenced on the Organizational Chart.
V. HOW POLICIES ARE FORMULATED

A. University Policies

University policies are those that have been approved by the President and the Vice Presidents of the University, and promulgated to the University community. Any person or committee may advance a policy to the President to be proposed as a University policy. The President and Vice Presidents review the proposed policy and take action appropriate to the content. After the appropriate review and approval has been made, the University policy is promulgated to the Vice Presidents, Deans, Directors named on the Organizational Chart of the University, the three libraries of the University, and updated on-line. It is the responsibility of those who receive new University policies to file them in the Guide to Policies of Creighton University and to make the policy available to those he/she supervises. The Guide in the three University Libraries is available to the University community and others for their review.

An announcement is placed in Creighton Today and emailed as a “CU_Official” message informing all employees that a new University policy or a revised policy exists and that the policy can be found in the offices of the President, Vice Presidents, Deans, Directors, the three libraries of the University, and on-line.

B. Policies for Offices/Departments

Policies for offices/departments within the Vice Presidential areas are generally reviewed by the Director with the Vice President. If the proposed policy affects another Vice Presidential area, the Vice Presidents mutually agree on the details of a final policy.

If Vice Presidents individually or collectively believe that the policy should become a University policy, then the policy is advanced to the President and Vice Presidents for review, consultation, and action. Vice Presidents have frequent meetings with the President at which time departmental policies can be reviewed before they become a policy of an office/department. General procedures, rules, and regulations are NOT considered official University policies unless they are committed to writing and approved by the President and Vice Presidents.

Most offices/departments make procedures for specific areas rather than policies.

C. Structural Guidelines for Formatting Policies

New University policies should be written in the following format:

1. **Purpose:** What is the reason for or the objective of this policy? Why does it exist?
2. **Policy:** State the policy.
3. **Scope:** To whom does the policy apply? Is there a specific group for which this policy is targeted, or a group which is excluded? For example, does a policy apply only to faculty and not to staff? Does it apply only to full-time and not to part-time employees?
4. **Eligibility**: How is a faculty member/employee eligible for this policy? For example, if the policy concerns benefits, some benefits may require one year or more of employment before an employee is eligible for coverage.

5. **Definitions**: This section should define any important terms used in the policy that need clarification to avoid misinterpretation.

6. **Administration and Interpretations**: Describe the parties responsible for administering the policy. This section may also indicate to whom questions regarding interpretation of the policy should be addressed.

7. **Amendments or Termination of This Policy**: States that the University reserves the right to modify, amend, or terminate this policy at any time. This section can also state that the policy is not a contract between Creighton University and its employees.

8. **Other**: Any items not falling into the preceding sections but worthy of comment can be stated in this section.

Specific sections should be included in a policy statement depending upon the policy's provisions.

NOTE: A "policy" is a written statement of management value. Policies are guidelines for general managerial actions that are used to promote continuity and understanding within the University.

A "procedure" promotes efficiency by explaining the steps by which a policy is implemented.

D. **Advisory Committees to the President**

There are a number of committees of the University which are advisory to the President. These committees may propose policies to the President.

1. **Standing Committees of the Academic Council**

Standing Committees of the Academic Council are established by the Academic Council according to the *Creighton University Statutes* to aid and advise on matters affecting faculty. Standing Committees give annual reports to the Academic Council. Members are elected from the faculty. The Vice President for Academic Affairs, Vice President for Health Sciences, and some administrators appointed by the President serve on specific committees. The *Creighton University Statutes* outlines the purpose, membership, and meeting time for each of the following Standing Committees:

- Board of Undergraduate Studies
- Committee on Academic Freedom and Responsibility
- Committee on Committees
- Committee on Faculty Dismissals
- Committee on Faculty Handbook and University Statutes
- Committee on Rank and Tenure
- Faculty Grievance Committee
2. **Presidential Committees**

Presidential Committees are committees established by the *Creighton University Statutes* to aid and advise the President on various University matters. Presidential Committees report directly to the President and normally give an annual report to the Academic Council. Some members are elected by the faculty and staff to serve on specific Presidential Committees. Students are appointed by the Executive Committee of the Creighton Students Union to serve on specific committees. Some members are nominated for membership by the National Alumni Board. Some members are appointed by the President. The *Creighton University Statutes* outlines the purpose, membership, and meeting time for each of the following Presidential Committees:

- Americans with Disabilities Act Committee
- Campus Planning Committee
- Financial Advisory Committee
- University Athletic Board
- University Committee on Benefits
- University Committee on Lectures, Films, and Concerts
- University Committee on Public Honors and Events
- University Committee on Student Discipline
- University Committee on Student Life Policy
- University Committee on the Status of Women
- University Grievance Committee
- University Staff Advisory Council

3. **Committees Appointed by the President**

Membership on these committees is not governed by the *Creighton University Statutes*. Members are appointed by the President to advise him on matters of specific importance.

The committees appointed by the President are the following:

- Academic Administrators’ Council
- Campus Safety Committee
- Conflict of Interest Review Committee
- Council of Deans
- Creighton University Wellness Council
- Diversity Coordinating Committee
- Government Relations Committee
- Harassment and Discrimination Committee
- Institutional Animal Care and Use Committee
- Institutional Biosafety Committee
- Institutional Review Board
- Intellectual Property Board
- President’s Advisory Board Committee
- President's Cabinet
- Radiation Safety Committee
- Radioactive Drug Research Committee
- Research Advisory Committee
- Research Compliance Committee
Other committees and task forces exist at the University to assist in the general work of the University.

For more information or clarity concerning information in this Guide, please call the General Counsel’s office at 402-280-5589.
Creighton, a Jesuit University, is convinced that the hope of humanity is the ability of men and women to seek the truths and values essential to human life. It aims to lead all its members in discovering and embracing the challenging responsibilities of their intelligence, freedom, and value as persons.

We therefore profess, and pledge ourselves to teach in the perspectives of, the following creed:

We believe in God, our loving Creator and Father.

We believe in the intrinsic value of the human being as created in God's image and called to be his child. This includes all persons and excludes any form of racism and other discrimination.

We believe that the deepest purpose of each man and woman is to create, enrich, and share life through love and reverence in the human community. This motivates our open and relentless pursuit of truth. For this reason we foster reverence for life in all its human potential.

We believe that we should support all persons in their free and responsible life-sharing through family and social systems, and through political, scientific and cultural achievements.

We believe that we must strive for a human community of justice, mutual respect, and concern. In this context we must cultivate respect and care for our planet and its resources.

We believe that laws exist for the benefit and well-being of individual persons, that legal systems must express the common good, and that all government must be subject to the courageous, though respectful and loyal, criticism of intelligent and responsible citizens.

We believe that the law of justice and love must regulate the personal, family, economic, political, and international life of all persons if civilization is to endure.

We believe in the teachings and example of Jesus Christ.
Creighton is a Catholic and Jesuit comprehensive university committed to excellence in its selected undergraduate, graduate and professional programs.

As Catholic, Creighton is dedicated to the pursuit of truth in all its forms and is guided by the living tradition of the Catholic Church.

As Jesuit, Creighton participates in the tradition of the Society of Jesus which provides an integrating vision of the world that arises out of a knowledge and love of Jesus Christ.

As comprehensive, Creighton's education embraces several colleges and professional schools and is directed to the intellectual, social, spiritual, physical and recreational aspects of students' lives and to the promotion of justice.

Creighton exists for students and learning. Members of the Creighton community are challenged to reflect on transcendent values, including their relationship with God, in an atmosphere of freedom and inquiry, belief and religious worship. Service to others, the importance of family life, the inalienable worth of each individual and appreciation of ethnic and cultural diversity are core values of Creighton.

Creighton faculty members conduct research to enhance teaching, to contribute to the betterment of society, and to discover new knowledge. Faculty and staff stimulate critical and creative thinking and provide ethical perspectives for dealing with an increasingly complex world.
To call a university Jesuit today is to specify a particular framework of thought and an inner intensity of person which seeks to communicate an awareness of Biblical transcendence and of the presence of Jesus Christ, the God man, in the midst of the growing development of man's intellectual achievements.

Such "Jesuitness" is by no means restricted to members of a single religious order. It is a quality or "style" of teaching and of thought-structure in which we invite and expect all the members of our University community to participate. Such a mark, or stamp, or character, or style prescinds from invidious comparison with others and it is surely not restricted to teachers who happen to be Jesuits.

While it is obvious that such presence is not determined by the size of the Jesuit Community at Creighton, it is equally evident that a strong and healthy Jesuit community must be recruited and maintained if the institution is to have its Jesuit characteristic. We do not and could not interpret this statement to mean that Jesuits hold a superior or sheltered position at Creighton. It must, however, mean that a kind of Affirmative Action is required, by which Jesuits with full preparation and demonstrated ability will be recruited and employed whenever possible in our University.
**PURPOSE**

The purpose of Creighton's policy on racism is to underscore the University's commitment to the fair and humane treatment of all members of the Creighton community. Adherence to this policy promotes ideals consistent with the University's credo and its mission.

**POLICY**

"We are vigorously opposed to all forms of 'racism' — persecution or intolerance because of race."

This statement amply expresses the Creighton policy with regard to all words or actions in any way involving relationships among the races of the human family.

We are a Christian university. We intend to cultivate a Christian environment and to develop a vital Christian community on our campus — a community that embraces the entire university, students, faculty, administrators, and staff. It is evident that such a community cannot and will not tolerate any kind of discrimination or any evidence of bigotry based on racial differences, real or supposed.

"Any physical or verbal assault," as our Student Handbook states, "shall be subject to University disciplinary action." This regulation must be considered as applicable not only to students but to faculty, administration, staff, and all who in any way represent Creighton.

**SCOPE**

This policy applies to all employees of the University.

**DEFINITIONS**

**Racism** can be defined as persecution or intolerance because of the race to which the individual belongs.
Creighton University, in its public and official identity as a Catholic university, is committed to certain principles of the moral, intellectual, and religious order. Its policies and programs must, in fidelity to its purpose, conform to these principles. Although the fundamental principles are, for the most part, universally understood and need no explicit mention, in matters of possible ambiguity a clarification is in order.

Because of laws in various states legalizing abortion, it seems prudent to remove from any misunderstanding the University's position on this subject. The University reaffirms the sanctity and inviolability of human life and vigorously opposes abortion as a morally acceptable option for unwanted pregnancies, and it expects any use of its name, facilities, and resources to reflect its position.
Creighton University, inspired out of a Catholic and Jesuit tradition, treasures the innate dignity of each member of our community and upholds the sanctity of each human being as a profound gift of God. Finding the resplendence of the divine reflected in the uniqueness of every person, we seek, acknowledge and celebrate diversity at Creighton because our Catholic and Ignatian heritage inspires and impels us to do so.

Diversity in principle is the “service of faith in the promotion of justice.” Diversity enhances our social selves and intellectual lives by exposing all of us to methods, styles and frames of reference that challenge our unexamined assumptions helping us unmask personal, cultural, institutionalized, and organizational discrimination and stigmatization, recognizing that ignorance and stereotypes create and sustain privileges and preference for some, while creating and sustaining marginalization and oppression for others.

In a truly Catholic context, diversity at Creighton commends inclusion as a prudential, virtuous, and practical principle. Celebrating diversity at Creighton is an invitation to incarnate our mission to educate lifelong learners who will be agents for change in our local communities and in the world. Diversity at Creighton animates our varied intellectual pursuits and enriches our mission to “seek Truth in all its forms.”

To this end, Creighton faculty, staff, students and administrators seek to foster an environment of awareness, inclusion, and compassion for everyone in our community and our guests, regardless of age, culture, faith, ethnicity, immigrant status, race, gender, sexual orientation, language, physical appearance, physical ability, or social class. Our caring, hospitable community, our attention to those who are underserved, our academic and co-curricular offerings, and our admissions, hiring, and promotion policies all give testimony to our desire to make Creighton a welcoming, inclusive community. We do this by constant vigilance and reassessment of our campus climate, reaching out to those who are marginalized and whose voices are muted by the mainstream.
It is important that Creighton University speak with a unified voice, especially on matters of University policy, sensitive issues, legal matters and in emergency situations. As the University's primary voice to the news media, the Department of Public Relations and Information serves as the clearinghouse for information on these matters.

All media inquiries dealing with University policy, emergency situations, legal matters or issues of University-wide concern should be directed to the Department of Public relations and Information. Faculty, administrators and staff should never assume the role of spokesperson for the University unless they have been asked to take that role by the Manager of Media Relations, Public Relations Director or by the University President.

However, the University also recognized that many of its faculty members possess expertise that is of interest to the news media.

Therefore, Creighton faculty members, administrators and staff are permitted and encouraged to comment to the news media in areas related to their academic or administrative expertise. Faculty, administrators and staff should alert Public Relations when they are interviewed by the media to assist the department in tracking media contacts.

Public Relations is available to assist faculty, staff and administrators in preparing for media interests or handling media inquiries. Contact the Manager of Media Relations at extension x2738 for assistance.
GUIDING PRINCIPLES

Creighton is a Jesuit and Catholic private university. As Catholic, Creighton is committed to identification with a specific religious tradition and all of its essential values. As a university, Creighton University is committed to its role as an academic institution in which the widest possible freedom of expression and openness to diverse ideas should be responsibly presented and examined, including critical examination of ideas and perspectives which may be or may appear to be incompatible with its Catholic tradition and mission.

An essential element in the Jesuit tradition is an emphasis on encouragement of active dialogue in the classroom, understanding traditions more deeply, and expanding awareness of diverse cultures and beliefs. Fostering intellectual, ethical, social and religious dialogue is fundamental to the development of intellectual exchange and social awareness in Creighton students and is integral to the nature of the university.

Creighton University has a responsibility to foster intellectual engagement and explore new ideas, new approaches and new cultures, but, as a Catholic university, Creighton has the added responsibility of fostering engagement among these perspectives and forms of knowledge with the Catholic intellectual tradition.

Creighton University is committed to presenting fairly and accurately the Catholic positions on social, moral and all other issues.

PURPOSE AND SCOPE

This policy explains the process to be followed when inviting an outside speaker or other artistic/creative presenter for a public event.

Additionally, this policy provides guidance in reconciling possible or perceived conflicts between Creighton's commitments as a Jesuit, Catholic institution and its commitments as a university when speakers or other artistic/creative presenters are invited by any Creighton University entity for public events. For purposes of this policy, “public event” means an event hosted, sponsored or funded by any Creighton University entity, including an event hosted, sponsored or funded by the Creighton Students Union, whether or not held on campus, which involves an outside speaker or other artistic/creative performer and at which persons other than the members of the inviting group are reasonably expected to be in the audience.
EXCLUSION FROM THIS POLICY

This policy does not apply to outside speakers or other artistic/creative performers invited by faculty members in the regular conduct of a scheduled University course. The Academic Freedom and Responsibility provisions of the Faculty Handbook guide faculty members in this regard.

APPROVAL PROCESS – GENERALLY

An academic department, University-registered student organization, Center Director, endowed chair, administrative office/department of the University, other Creighton University entity or the Creighton Students Union (the "Inviter") that wishes to invite an outside speaker or other artistic/creative performer for a public event is expected to use responsible judgment and the framework of this policy in selecting the speaker or other artistic/creative performer, in setting the framework of the event, in publicizing the event and in all matters materially related to the event.

If an invitation is extended, the Inviter must have a written agreement with the speaker or other artistic/creative performer confirming the details of the event. Inviters are encouraged to use the University's standard contract routing procedure to process such agreements. If the public event is to be held on campus, the Inviter must schedule the event with the Division of Student Services or the academic or departmental office that schedules the requested facility.

APPROVAL PROCESS – POTENTIAL CONTROVERSY

If it is reasonably likely that a potential speaker or other artistic/creative performer will espouse or appear to espouse positions in conflict with Creighton's traditions and values, the Inviter must inform the relevant Vice President of the planned invitation and provide the Vice President with background information about the invitee's positions, works, published speeches and other relevant information to allow the Vice President to make an informed judgment as to whether and under what circumstances (including but not limited to the format of the event) the invitation should be extended.

In making that judgment, the Vice President should seek input from potentially affected interested parties as well as an ad hoc consultative group created by the Vice President consisting of persons with subject matter expertise to help guide the decision making process concerning holding the public event on Creighton's campus.
**Policies and Procedures**

**SECTION:**
Administration

**NO.:**
2.1.2.

**CHAPTER:**
General

**ISSUED:**
3/7/88

**REV. A:**
10/28/08

**REV. B**

**POLICY:**
Speakers and Artistic/Creative Presenters Policy

In the case of an invitation requiring review by the relevant Vice President, that Vice President should be given 30 days advance notice of the proposed invitation.

**NO CONNOTED ENDORSEMENT**

The scheduling of public events does not necessarily connote Creighton University's approval or endorsement of the views expressed at such events.

**ISSUES AFFECTING CREIGHTON AS A TAX EXEMPT ORGANIZATION**

As a tax-exempt organization under section 501(c)(3) of the Internal Revenue Code, Creighton cannot participate or intervene in any political campaign. The University refrains from sponsoring programs designed to raise funds for political candidates or parties. Creighton may provide opportunities for legally qualified candidates for public office to speak on the University campus subject to applicable laws and IRS guidelines.

**RESERVATION OF RIGHTS**

Creighton University reserves the authority to cancel or refuse to allow any public event whose nature or presentation or support of an issue is contrary to or inconsistent with the University's mission and/or its Jesuit, Catholic identity or if the University cannot assure the adequate safety of the Creighton community or the invited speaker or persons participating in the event. The final determination in this regard shall be made at the discretion of the President or the President’s designee.
Both the official Creighton University emblem and the Bluejay athletic emblem are registered with the U.S. Patent Office. Creighton University has exclusive ownership rights regarding the use of these emblems as well as the Creighton University name.

It is in the best interest of the University to set certain standards governing the use of these emblems and the name in terms of appropriateness and good taste, to protect against over-commercialization of the University's name and emblems, and to secure reasonable compensation through authorized use by commercial enterprises.

Whenever these emblems are used by University organizations, its affiliates or authorized non-affiliates, the emblems must carry the proper registration mark as shown. The exception: when used on University stationery, envelopes, business cards and formal invitations.

Official contracts, duly signed by the contract officer of Creighton University and by the authorized official of the using organization, are required when these emblems or the Creighton name are to be used for commercial enterprise for fund-raising projects by affiliated organizations, such as student or faculty groups, or by unaffiliated organizations. Requests for these contracts can be made through the Department of Public Relations and Information.

Permission may be granted to affiliated or unaffiliated organizations for not-for-profit use by a letter or authorization for a specific purpose through the Director of Public Relations and Information or his/her designated representative. Advertisers in official University programs, athletic programs and other official Creighton publications do not require contracts or written authorization for use for those purposes.

Alterations or variations of the University seal (emblem) are not permitted. Those using the Bluejay emblem are strongly urged to use the registered trademark version. Any variation must be approved through the Department of Public Relations and Information and must closely approximate the trademarked version.
Student publications and broadcasting will follow these guidelines:

1. Advertising which is in violation of any local, state, or federal law or regulation will not be published or broadcast.

2. Advertising which promotes a product, service, or cause contrary or hostile to the moral and religious principles set forth in the Creighton Credo will not be published or broadcast.

3. Advertising whose claims are fraudulent, misleading, or grossly unsubstantiated, or which appear to require further substantiation for the protection of consumers, will not be published or broadcast until sufficient substantiation of claims is made.

4. Advertising for products or services which may be injurious to health will not be published or broadcast.

5. Ordinarily, only advertising which carries the signature or identification of a responsible advertiser will be published or broadcast so that consumers may know whom to contact regarding returns, adjustments, breach of warranty, etc. It is also highly encouraged to provide a phone number so individuals may contact the group for further information.

6. Entertainment or speaker/lecture advertising will need to comply with all current guidelines regarding posting and promotion as found in the Student Handbook. Advertising may also be examined for acceptability on more particular grounds, including the following:

   a. Advertisements, copy and/or illustrations which pander to a prurient interest in violence or human sexuality, or which denigrate the beliefs, customs, or physical attributes of ethnic or religious groups will be rejected.

Implementation Procedures

1. The Coordinator for Greek Affairs and Student Organizations shall be responsible for implementation of and adherence to the guidelines.

2. In case of any questions arising with regard to implementation or interpretation of any guidelines, the Coordinator of Greek Affairs and Student Organizations will confer with the Vice President of Student Life.
**Policies and Procedures**

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<td>POLICY: Telecast of Athletic Events</td>
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Creighton University's purpose in permitting telecasts of competition in which its athletic teams engage is to (1) achieve exposure for the University and its athletic programs and to (2) generate reasonable income.

Ordinarily, telecasts will not be permitted if ticket sales will be adversely affected.

Creighton University considers its athletic programs to be a significant part of its composition and of its primary mission of education.

Therefore, the University insists that there be a reasonable balance between major and minor, men's and women's athletic events allowed to be televised.

Creighton also recognizes that its students in communications and broadcasting curriculum should have the opportunity through the telecasts for laboratory production experience in remote sports productions.

The University wants the opportunity on occasion to help fulfill its obligation to participate in the programming of the Omaha Educational Consortium System by telecasts of selected Creighton athletic events. Telecasts of Creighton athletic events on this system may at times be given priority to fulfill the University's obligation to the consortium and its concomitant educational mission. However, Creighton recognizes the special needs, attractiveness, and potential of commercial television enterprises.

Accordingly, in the spirit of cooperation to meet their needs, Creighton University on a regular basis will supply interested television companies with schedules of all athletic events that the University will allow to be televised. The television company will then select those contests that it wants to originate for its own programming on its own channel, at its own expense and time, by a predetermined deadline. There must be a commitment at an agreed upon date. The University will do its best to honor these requests and confirm rights to specific event telecasts.

Following determination of what events the television system will be permitted to telecast, the units of the University responsible for programming the Educational Consortium channels will arrange for telecasts of other specific events with the Athletic Department of the University. Assignment of rights to telecast specific events will rest primarily with the Athletic Department, but what best serves the long-range interests of the University in its total context as an institution of higher learning in the judgment of its administration always must be the primary consideration.
Post-season events (not pre-scheduled) are governed by the same policy.

The University expects the television system to advertise and promote those Creighton University athletic events that it is granted the right to telecast.
Policies and Procedures

SECTION: Administration

CHAPTER: General

POLICY: Use of University Facilities by Non-University Groups

PURPOSE

Creighton's policy on the use of Creighton University facilities by non-university groups was designed to support the mission of the University, to give students, employees, and official University functions highest priority in the use of University facilities, to guard the University against undue liability, and to protect the University's non-profit tax exemption status.

POLICY

1. In considering any request to use Creighton University facilities, the University's purpose and needs must be kept in mind. Ordinarily, only requests from nonprofit organizations which enhance or promote activities consistent with Creighton's goals and traditions will be considered. University facilities may be made available only to organizations which will not use such facilities for immediate financial gain or profit. This is essential in order to maintain Creighton University's stated charter and tax exemption status.

2. Creighton University will not consider applications for use of its facilities when to do so would compete with similar facilities operated by private enterprise or under government authority.

3. No admission or other charges shall be made by the applying organization for any event which will exceed the reasonable expenses incurred by the organization in sponsoring and holding such event, except when all proceeds are committed to charity. An event budget, including income and expenses, may be required if admission charges appear to exceed a reasonable rate.

4. Organizations sponsoring an event for which University facilities will be used shall agree to indemnify and hold harmless Creighton University for and from any claim or loss to the University by reason of any damages resulting in any manner from such use of Creighton's facilities, including damages to Creighton's property, and injuries to any person or persons, including injuries resulting in death.

If extraordinary risk appears to be involved, the sponsoring organization may be required to supply the University with a Certificate of Public Liability insurance naming Creighton University as additional insured in the amount of no less than $300,000 for bodily injury per occurrence and $100,000 property damage per occurrence. This would insure Creighton against claims of any persons arising out of the use of the premises or facilities.
5. In addition to the applicable laws and public regulations, Creighton shall have the right and authority to specify such further reasonable regulations as regarded necessary for the proper use of its facilities to any sponsor.

**SCOPE**

This policy applies to all non-University groups seeking to use Creighton University facilities.

**PROCEDURES**

Each Vice President and his or her Deans or Directors are in charge of University space assigned to them and have policies and procedures relating to the frequency and type of activities for which they allow the space to be used. The office in charge is responsible for the good name of the University and the safety of its property, and should therefore scrutinize all requests carefully. All requests for use of University facilities must be made through the office responsible for each individual area.

The office in charge of each specific area of the University has developed fee structures governing the use of the facilities for which they are responsible. These fees are to be collected prior to actual use of the facilities. The office in charge of an area may waive some or all of the fees depending on the specific policies and procedures governing their area.

Additional charges may be assessed depending on the specific nature of the event. If an event requires any type of special arrangements, these need to be made through the appropriate departments. For example, security guard service may be required, in which case special arrangements need to be made through the Creighton University Department of Public Safety.

If food is to be served, the sponsor must contract with the University's food service contractor. Exceptions must be cleared through the Office of the Vice President for Student Life or that of the Director or Dean responsible for the area.
**Policies and Procedures**

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**POLICY:**

Use of University Facilities by Non-University Groups

**ADMINISTRATION AND INTERPRETATIONS**

Questions about the use of University facilities may be directed to any of the offices responsible for reserving facilities. In addition, the Office of the Vice President for Student Life may be a helpful resource.

**AMENDMENTS OR TERMINATION OF THIS POLICY**

Creighton University reserves the right to modify, amend, or terminate this policy at any time.
**Policies and Procedures**

**SECTION:** Administration

**CHAPTER:** General

**ISSUED:** 11/11/83  
**REV. A** 6/26/08  
**REV. B** 6/6/12  
**REV. C**

**POLICY:** Contracts with Outside Groups

**PURPOSE**

To protect the legal interests of the University, only authorized individuals are permitted to execute agreements which bind the University to one or more external parties.

**POLICY**

Contracts involving the University and external parties must be reviewed and approved as specified in the University Contract Procedures found at [http://www.creighton.edu/finance/](http://www.creighton.edu/finance/).

Multi-year vendor contract agreements with committed expenditures of $1 million or more require approval of the responsible Board Committee and the Budget and Finance Committee of the Creighton University Board of Trustees.

**SCOPE**

The policy applies to all contracts and agreements binding the University to any unrelated party.

**PROCEDURE**

All contracts must be routed using the corresponding External Contract Control Sheet found at [http://www.creighton.edu/finance/](http://www.creighton.edu/finance/) to ensure the appropriate review and approvals are obtained prior to execution of the contracts.

All contracts, except for the following list, must be signed by the Vice President for Finance, the President, or an authorized designee. Exceptions include:

- Grant contracts
- Marketing and communications advertising agreements
- Renewal of existing service agreements under $25,000
- Letters of Transmittal for Faculty Appointments
- Student Clinical/Experiential Affiliation Agreements with no financial consideration
- Athletics Game Guarantee contracts
- Athletic Sponsorship contracts
Scanned copies of fully executed contracts requiring signatures of the Vice President for Finance, the President, or an authorized designee, will be stored in the Creighton University document management system following execution of the contracts.

ADMINISTRATION

This policy is administered by the Office of the Vice President for Finance.
Policies and Procedures

SECTION: Administration  NO. 2.1.8.

CHAPTER: General

POLICY:

Copyrights of Digital Materials and Software

PURPOSE

The purpose of this policy is to outline the University's policies on use of software and digital materials that are copyright protected and to identify the person to receive notification from copyright owners of claimed copyright infringement.

POLICY

The University is committed to academic freedom regardless of the medium of expression. However, it is the policy of the University to respect the copyright protections given by federal law to owners of software and digital materials. It is against University policy for Users to use Information Resources to access, use, copy or otherwise reproduce, or make available to others any copyright-protected digital materials or software except as permitted under copyright law (e.g. fair use doctrine) or specific license.

Information posted on any University system must comply with federal copyright laws.

The University regards any violation of this policy as a serious matter and any such violation is subject to appropriate disciplinary action, including removal of the material from Information Resources. Repeated violations will result in termination of computing privileges in addition to other sanctions.

Pursuant to the Digital Millennium Copyright Act (37 CFR 201.38), the University has designated the following individual to receive notification from copyright owners of claimed copyright infringement.

University General Counsel
Creighton University
2500 California Plaza
Omaha, NE  68178
(402) 280-5589 – telephone
(402) 280-5719 – fax

This contact information shall be posted on the University's web site.
SCOPE

This Policy applies to faculty, staff, students, alumni and all other persons authorized to use the University's Information Resources ("Users") whether accessing those Information Resources on campus or remotely. Disciplinary action for violating the policies shall be governed by, but not limited to, the applicable provisions in this Guide to Policies of Creighton University and any applicable sections of federal and state law. Users who violate this Policy may have, at a minimum, the alleged infringing material removed from Creighton's Information Resources pending evaluation of the alleged violation. In each case corrective action shall be tailored to redress the severity of the particular violation or violations.

DEFINITIONS

Information Resources. Information Resources include all computer and telecommunications hardware, software and networks, owned, leased or operated by the University and the information stored therein.

Users. All persons who have access to and use of Creighton's Information Resources, including, but not limited to faculty, staff, students, alumni, guests and other authorized individuals.

ADMINISTRATION AND INTERPRETATIONS

The above policy statements are intended to work to the benefit of all who use Creighton University's Information Resources by encouraging responsible use of scarce computer resources. Users deemed in violation of these policies will be immediately notified of the nature of the complaint and may have their access temporarily suspended. Any notice will provide information on the alleged copyright infringement and the User's rights and obligations.

RESOURCES

Educational materials on copyright protections and exemptions are available through the Reinert Library at http://reinert.creighton.edu/aboutlib/policies/copyright/reservecopyright.htm#asst and Health Sciences Library at http://www2.creighton.edu/health/library/services/obtaincopyrightpermission/index.php.
All University mailings must be processed through the Creighton University Mail Center. No mailings will be sent to outside contractors such as Acme, A-1, Interstate, etc., without the approval of the Mail Center Director.

All mailing expenses, including postage, express mail, and any labor associated with mail preparation will be billed back to the originating department.

No University employee shall enter into an agreement, either oral or written, with any non-University individual or company, which presumes the processing of mail by the University Mail Center without the express, written consent of the Vice President for Administration.
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Attended visitor parking for guests and parents is available Monday through Friday from 8:00 a.m. to 5:00 p.m. at the northeast corner of 24th and Cass Street. After hours and on weekends, access may be obtained by using the Direct Dial, Public Safety Callbox located on the Guardhouse at the entrance. Special accommodations for larger groups or conferences may be arranged through the Department of Public Safety.
**Policies and Procedures**

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**PURPOSE:**
The purpose of this policy is to communicate the University’s contractual commitments with its food service provider, Sodexo Campus Services.

**POLICY:**
Sodexo Campus Services has been designated as the official and exclusive contracted food service for Creighton University’s Campus Dining Services’ programs. Sodexo will have exclusive catering rights for the University. Exceptions will be made in catering with the General Manager’s approval. Appeals to the General Manager’s decision will be made to the Assistant Vice President for Student Life who will have final say on variances from the contract. The guidelines of the Ethnic Food Policy will sometimes be applied if the event that is being excepted falls within its conditions. Other exceptions may be made on an event-by-event basis with approval from the Assistant Vice President of Student Life after consultation with the General Manager of University Dining Services.

**SCOPE:**
All activities, social events, public meetings, private events, conferences or other gatherings involving food and beverages, including alcohol on campus are required to make appropriate arrangements with University Dining Services.

**PROCEDURE:**
It is recommended that food and beverage orders be placed three weeks in advance by contacting the Catering Department in the Skutt Student Center or the Harper Center or by calling 280-2446.

Any exceptions to this contractual arrangement must request to do so by completing a Waiver of Exclusivity form available on-line at http://www.creighton.edu/fileadmin/user/SkuttStudentCenter/docs/USFPWaiverExclusivity22307.pdf.

**ADMINISTRATION:**
This policy is administered by the Office of the Vice President for Student Life.
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**PURPOSE**

Creighton's policy on employee use of personal vehicles for University business is designed to maximize convenience to faculty and staff, and to conduct University business as efficiently as possible, while protecting the individual employee and the University from undue liability in the event of accident.

**POLICY**

Use of personal vehicles on University business is permitted.

State regulations require that insurance coverage for a vehicle must be retained by the vehicle owner. Initial insurance claims on the vehicle are always made to the owner's insurance policy. The University cannot be responsible for damage to an employee's vehicle while the vehicle is in use on University business. Since the employee must look to personal auto insurance coverage if an accident occurs, it is important that adequate limits of personal liability and physical damage coverage be maintained on your vehicle.

The University's auto liability insurance is excess over an employee's personal auto liability insurance for third party bodily injury and third party property damage claims that may arise.

**SCOPE**

This policy applies to all University employees.

**PROCEDURES**

All University business-related travel should be approved by the employee's supervisor in advance.

**ADMINISTRATION AND INTERPRETATIONS**

The University's Human Resources Department, the Director of Human Resources, and the Purchasing Department, encompassing fleet management, will all be helpful in answering questions with regard to this policy.

**AMENDMENTS OR TERMINATION OF THIS POLICY**

Creighton University reserves the right to modify, amend, or terminate this policy at any time.
Policies and Procedures

SECTION: Administration

NO. 2.1.13.

CHAPTER: General

ISSUED: 1988
REV. A 4/24/97
REV. B 10/24/12

POLICY: Noncommercial Aircraft

PURPOSE

Creighton University's noncommercial aircraft policy is designed to protect employees and the University from liability related to air travel during University or University-related business.

POLICY

In certain instances, travel on noncommercial aircraft may be more economical or more efficient than commercial air travel. Prior to traveling on a noncommercial aircraft, the employee is responsible for verifying that the owner of the aircraft has the following minimum levels of liability insurance coverage:

i) Fewer than ten passengers $5 million
ii) Over ten passengers $50 million

Unless an exception is granted as outlined in Administration and Interpretation, no University employee may act as pilot, copilot, or crew member of any airplane, helicopter, or other aircraft while traveling on or performing University or University-related business. This includes attendance at meetings, seminars, or conventions relating to University business or professional development.

SCOPE

This policy applies to all employees of Creighton University.

ADMINISTRATION AND INTERPRETATIONS

Questions about this policy can be directed to the University Risk Management Office for review.

Request for exceptions must be made by submitting a completed Employee Operated Aircraft Questionnaire through the appropriate Vice Presidential Office to the Senior Vice President for Operations. Copies of the completed, approved Questionnaires will be retained in the University Risk Management Office. Approvals must be updated annually.

AMENDMENTS OR TERMINATIONS OF THIS POLICY

Creighton University reserves the right to modify, amend, or terminate this policy at any time.
Policies and Procedures

SECTION: Administration

NO. 2.1.14.

CHAPTER: General

ISSUED: 4/3/96

REV. A

REV. B

POLICY: Vehicle Safety

PAGE 1 OF 7

PURPOSE

This policy has been developed to define standards of conduct and establish mandatory training for faculty, staff, students and volunteers who operate motor vehicles while conducting Creighton University business. The primary goal of this policy is to help prevent accidents and minimize the risk of personal injury associated with those incidents.

POLICY

Driving History Review. A review of the driving history of all individuals will be conducted prior to hire, transfer or promotion into a position that requires the frequent operation of a motor vehicle for University business. Persons applying for new employment will not be eligible for hire, and current Creighton University employees will not be eligible for transfer or promotion into positions requiring them to frequently operate a motor vehicle if their driving history record reveals any of the following within the previous 24 months.

A revocation or suspension of driver's license in any state.

A major violation such as reckless driving, negligent driving, or driving under the influence of alcohol or other controlled substance.

Convictions for traffic offenses totaling six or more Nebraska Motor Vehicle points within the last two years.

Current Creighton University motor vehicle operators whose annual driving history review reveals any of the aforementioned will be placed on probation for two years with any subsequent violation resulting in disciplinary action up to and including termination of employment.

Driver's License. All University motor vehicle operators must be in possession of a valid driver's license from their state of residence. They must also sign the Vehicle Use Acknowledgment Form that allows the Risk Management Office to obtain state driving records. In the event that an employee's job description requires him or her to drive a "commercial vehicle," the employee will be required to obtain and maintain a valid Nebraska commercial driver's license.

Vehicle Operator Responsibility. Motor vehicle operators must report all traffic citations received while on University business to their department head. They must also report the onset of any physical or mental condition that may impair their ability to drive.
Motor vehicle operators are required to conduct a vehicle safety inspection prior to the operation of the vehicle. Windows and mirrors must be scraped and defrosted during inclement weather. Deficiencies or any mechanical defect that would jeopardize the safe operation of the vehicle (such as a leaking gas line or overheating engine) must be corrected immediately. Vehicles found to be in unsafe condition are not to be operated until repairs are made. It is the responsibility of all motor vehicle operators to drive in a safe manner and conform to all applicable laws and regulations.

Motor vehicle operators must:

- Wear seat belts/shoulder harnesses as provided in the vehicle.

- Avoid wearing radio headsets or listening to loud music that would prevent them from hearing traffic warning devices.

- Utilize mechanical and/or hand signals at all times to inform others of their intentions.

- Adhere to all Creighton University Traffic and Parking Regulations when operating or parking a University-owned vehicle on campus.

Ensure that the vehicle is secured when parked by:

- Turning the ignition switch off and removing the key.

- Making sure that vans and all other vehicles equipped with automatic transmissions are placed in "park" and that vehicles equipped with manual transmissions are placed "in gear."

- Setting the hand brake.

- Chocking the rear wheels of the vehicle, or turning the front wheels toward the curb when the vehicle is parked on an incline.
Ensure the safe transport of all materials and goods by:

- Securely fastening all loads, regardless of weight or height, to prevent rolling, pitching, shifting or falling. No one will be allowed to physically "steady" a load while riding in the back of the vehicle.

- Securely fastening all doors while the vehicle is in operation.

- Securing tailgates in an upright position while the vehicle is moving, except when the load exceeds the length of the vehicle bed.

- Affixing a red flag to the end of any load that extends two feet or more beyond the end of the vehicle.

- Ensuring that loads do not extend beyond the width of the vehicle.

Ensure the safety of all passengers by:

- Requiring them to use seat belts.

- Not allowing any passengers to routinely ride in the bed of a truck. However, when any passengers must ride in the bed of a vehicle, they must be seated at all times. **Passengers will not be allowed to sit on the tailgate or sides of the vehicle nor extend their arms or legs beyond the vehicle while it is moving.**

- Prohibiting any passenger from riding on a trailer while it is being towed.

- Prohibiting more than two passengers in the front seat of any vehicle unless additional seat restraints have been installed.

- Prohibiting any passenger from riding between bucket-type seats, on the engine cowling or placing a chair between the seats while the vehicle is moving.

- Drive defensively at all times.
**POLICY:** Vehicle Safety

**Department Head Responsibility.** Department heads are responsible for ensuring that University-owned vehicles are operated by authorized Creighton University motor vehicle operators only. They are also required to conduct an annual driver's license review to verify that each motor vehicle operator holds a valid license and is complying with all restrictions.

Department heads must also:

- Immediately notify the Risk Management Office and Human Resources if a vehicle operator's license has been suspended or revoked.
- Ensure that all employees and students who frequently operate a motor vehicle on University business attend a vehicle safety class within 90 days of their employment date, and before they operate a University-owned vehicle.
- Require that each supervisor review the Vehicle Safety Policy with each new employee before authorizing the employee to operate a University-owned vehicle.
- Schedule additional training as required to ensure the safe operation of special purpose vehicles, such as sweepers, snow plows, riding lawn mowers, etc.
- Document all training and provide copies to Human Resources for inclusion in the employee's personnel record.

**University Responsibility.** Creighton University is responsible for equipping each University-owned vehicle with safety equipment necessary for safe operation during inclement weather. Snow tires, chains, additional lights, ice scrapers and other safety equipment will be provided in those vehicles as needed. The University will also equip each of its vehicles with a fire extinguisher.

**Accident Reporting.** It is the responsibility of all Creighton motor vehicle operators to report all accidents, regardless of damage. Accidents that occur on University property must be reported immediately to Public Safety (280-2104). Accidents that occur off Creighton University property must be reported immediately to the appropriate law enforcement agency and to the Risk Management Office as soon as practical. If an accident occurs on University property:
Call or have someone call Creighton Public Safety at 280-2104 and provide information about the accident. Do not leave the scene or move the vehicle until advised to do so by a Public Safety Officer.

Assist injured persons, but do not attempt to move them unless a threat to life exists.

Report the accident to your supervisor as soon as practical.

Obtain the names of witnesses, insurance information and other pertinent facts. Forward the information to the Risk Management Office as soon as possible. An accident report form will be placed in the glove box of all University-owned vehicles.

Notify Creighton Public Safety if you strike an unattended vehicle or object while on campus, but do not leave the scene until given permission by a Public Safety Officer.

If an accident occurs off campus property:

Contact the appropriate law enforcement agency.

Obtain the name, address and insurance company of any and all drivers and witnesses involved in the accident. Also record the name and badge number of the officer who takes the report.

Request a copy of the incident report or obtain the case number associated with the accident if a copy is not immediately available.

Report the incident to your supervisor as soon as practical.

**Accident Review and Insurance.** The Risk Management Office and the Environmental Health and Safety Office will review each accident that involves a University-owned vehicle and each incident where a vehicle operator has been cited for a violation of Motor Vehicle Law, or the Creighton University Vehicle Safety Policy, while operating a vehicle on University business.

Risk Management will maintain a driving record on each employee driver. Risk Management will notify the appropriate department head in writing to schedule a Vehicle Safety Class for any employee who:
Has been involved in an accident and was cited by the investigating police officer or was determined to be at fault in the accident by Risk Management or Environmental Health and Safety personnel.

Has received two tickets for moving violations within one calendar year.

University insurance:

  Covers liability for personal injury and damage to the property of others. It does not cover deductibles associated with comprehensive or collision damage. Departments with vehicles assigned to them are responsible for any uninsured loss.

  Covers faculty, staff, students and volunteers while they are driving University-owned or rented vehicles. When employees operate their own vehicles while on University business, their insurance company will be considered as the primary insurer with the University's coverage being secondary.

  A contracted chartered bus service must maintain liability limits of at least $5 million and must name the University and its affiliates as additional insureds. They must also provide an acceptable certificate of insurance to Risk Management prior to service.

**Discipline.** Drivers who violate the Creighton University Vehicle Safety Policy are subject to disciplinary action as outlined in the "Supervisors Policy and Procedures Guide."

Department heads will send documentation for any disciplinary action associated with the enforcement of this policy to Human Resources and Risk Management for inclusion in the employee’s file.

**SCOPE**

This policy applies to individuals who, in the course of their employment, are frequently required to operate a motor vehicle, University-owned or personally-owned, to conduct University business.

**DEFINITIONS**

For the purpose of this policy, "motor vehicle operator" refers to any faculty, staff, student or volunteer, 18 years of age or older, who frequently operates a motor vehicle while conducting University business. "Frequently" shall be defined as once a week or more. Individuals who are under 18 years of age may not operate a motor vehicle to conduct University business.
This policy is administered jointly by the Department of Environmental Health and Safety and the Risk Management Office. Questions regarding this policy should be referred to the respective directors.
PURPOSE

To outline the policies and procedures regarding interaction between University personnel and external auditors or reviewers (federal, state, or private) who conduct audits and program reviews at Creighton University.

POLICY

1. It is the policy of Creighton University to cooperate with external auditors or reviewers in the performance of their duties and to provide access to relevant documents and data as requested, except those deemed by the General Counsel to be legally privileged or protected.

2. Persons who receive notice of an external audit or review should notify the President, appropriate Vice President, Dean (if appropriate), Internal Audit Director, General Counsel, and Vice President for Finance. The notice should be put in writing describing the nature and scope of the planned audit or review.

3. The Internal Audit Director shall function as a liaison among the external auditors or reviewers, the area subject to external audit or review, and the President, General Counsel, and Vice President for Finance.

   In certain situations with the approval of the President, other qualified and knowledgeable University personnel may function as the liaison.

PROCEDURES

1. Upon notification, all relevant correspondence and a summation of the audit or review should be forwarded to the President with courtesy copies to the Internal Audit Director, General Counsel, Vice President for Finance, Vice President of the area subject to audit or review, and Dean (if appropriate).

2. The Internal Audit Director, or approved liaison, shall coordinate and conduct an entrance conference with appropriate University personnel and the external auditor or reviewer. The objectives of this conference are to establish the purpose, scope, and timing of the audit or review; determine the information required by the auditor or reviewer; and arrange for physical facilities and equipment needed to facilitate an audit or review.
3. The Internal Audit Director shall be advised of progress and any difficulties encountered during the audit or review by University personnel.

4. The Internal Audit Director shall notify the President, the Audit Committee of the University’s Board of Directors, as directed by the President, and provide status reports.

5. At the completion of the audit or review, the Internal Audit Director, or approved liaison, shall coordinate and conduct an exit conference. The purpose of the exit conference is to inform University personnel of the audit or program review results. At this time, any misunderstandings are clarified and unresolved issues discussed. Minutes are to be taken at the meeting and made available to auditors or reviewers and appropriate University personnel.

6. In most cases, a written response to the audit or review findings will be requested from the University. The response is to be prepared by University personnel responsible for the area audited or reviewed. It is subject to review and approval by the Vice President of the area subject to audit or review, Dean (if appropriate), the Internal Audit Director, and General Counsel prior to issuance.

7. The final report shall be reviewed by the President, Internal Audit Director, General Counsel, Vice President for Finance, Vice President of the area subject to audit or review, and Dean (if appropriate).

8. All significant post audit or review correspondence shall be forwarded to the President, Internal Audit Director, General Counsel, Vice President for Finance, Vice President of the area subject to audit or review, and Dean (if appropriate).

9. The Internal Audit Director and General Counsel are to be consulted during the audit or review resolution phase.

ADMINISTRATION AND INTERPRETATIONS

Questions regarding the administration of this policy should be addressed to the Internal Audit Director. Questions regarding interpretation of this policy should be addressed to the General Counsel.
Policies and Procedures

SECTION: Administration

CHAPTER: General

POLICY: Advertising

PURPOSE

The purpose of the Creighton University Advertising Policy is to ensure the wisest use of University resources in the creation, production and placement of advertising and to ensure consistency in image, message, branding, timing, and graphic standards.

POLICY

Advertising placed by Creighton University departments to be paid by University funds or in-kind services will be approved by the Public Relations and Information Department. Advertising must be consistent with the University’s graphic standards and overall marketing goals, have adequate tracking mechanisms, be appropriately timed, and achieve economies of scale regarding rates and placements. The Public Relations and Information Department is responsible for the creation, placement and budget management of image advertising for the University. The Department serves as a consultant for all University departments regarding marketing planning and advertising and promotion strategy, budgeting, creative, production, placement and assessment.

SCOPE

This policy applies to all Creighton University employees, persons not employed by Creighton but who are contracted to create, produce or place print or electronic advertising in any media, locally or nationally, including videos, CD-ROMs, Internet banners, etc. It includes full or limited service agencies, independent free lance professionals, other vendors and media, all of which should become familiar with the University’s graphic standards.

This policy covers all print, outdoor, and electronic marketing tools and display type advertising directed to primary University audiences. Classified advertising for the purpose of hiring or recruiting employees is NOT covered by this policy. Advertising paid for through research grants is subject to grant restrictions, but the advertising director should be made aware of its placement.

It should be noted that the Public Relations and Information Department is not designed to be a full-service agency, but can advise and assist in the procuring of appropriate advertising services.

DEFINITION

Advertising under this policy includes, but is not limited to, print or electronic advertising in paid or in-kind media such as newspapers, magazines, maps, brochures, electronic signage, outdoor billboards, bus benches, television and radio commercials, Internet advertising and Yellow Pages (video and print).
## Policies and Procedures

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### PROCEDURES

Departments wishing to place advertising are urged to seek the input of the Public Relations and Information professionals early in the planning stages. The University’s advertising director can serve as the interface between departments and agencies, graphic designers, writers, vendors and media.

Ample lead time should be given appropriate to the scale of the project. In the case of a major, multi-media campaign, planning should take place several months before scheduled advertising dates. In the case of a simple small display ad, two to three weeks may be ample time for proper creative, production and placement.

Departments placing ads are responsible for adequate budgeting, PO numbers or direct pay orders. Each will also be responsible for tracking responses and evaluating them with the assistance of the advertising director.

### ADMINISTRATION

For guidance in interpreting and administering this policy, supervisors may contact the Human Resources Department of the University, the University’s Director of Public Relations and Information and the department’s advertising director.

### AMENDMENTS OR TERMINATION OF POLICY

Creighton University reserves the right to modify, amend or terminate this policy at any time.
I. PURPOSE

The primary purpose of the research compliance reporting process is to provide nonthreatening ways for employees and agents of Creighton University to report any activity or conduct that they suspect is not in compliance with the Research and Sponsored Programs Compliance Plan (Plan) or with applicable federal or state laws and regulations. Information received through the research compliance reporting process will be used to investigate, verify, and correct any identified noncompliant conduct in research or sponsored program activity.

II. POLICY

Employees, students, and agents of Creighton University who know or suspect that noncompliant conduct is occurring or has occurred in any research or sponsored program activities conducted and/or approved through Creighton University should report such conduct. No person shall be retaliated against by Creighton University or any of its employees, students, or agents for making a good-faith report of suspected noncompliant conduct in research or sponsored program activities.

III. SCOPE

This policy applies to all full-time and part-time faculty, administrators, staff, volunteers, students, and agents of Creighton University.

IV. PROCEDURE

Reporting Noncompliant Conduct

1. University research oversight committees, boards, and offices: Individuals who know or suspect that noncompliant conduct is occurring or has occurred should first discuss their concerns with their immediate supervisor, if appropriate. As necessary, concerned individuals should then contact the appropriate University research oversight committee, board, or office responsible for the element of research compliance in question, as described in the Plan. Concerned individuals who do not know which committee, board, or office to contact or who have a general research compliance concern should contact the Associate Vice President for Research and Compliance (402-280-2360).
2. **Research Compliance Hotline:** The Associate Vice President for Research and Compliance shall establish and maintain a Research Compliance Hotline (402-280-3200) to allow individuals to anonymously report noncompliance in research or sponsored program activities. Any person may call the confidential Research Compliance Hotline to report any known or suspected noncompliant conduct in research or sponsored program activities. Anyone who intentionally makes a false report or misuses the Research Compliance Hotline shall be subject to discipline.

**Confidentiality of Individuals Reporting Noncompliant Conduct**

All reports regarding suspected noncompliant conduct shall be maintained in a confidential manner to the extent allowed by law. Persons who wish to remain anonymous may report concerns using the Research Compliance Hotline.

Individuals receiving reports of noncompliant conduct shall maintain the confidentiality of the person making the report, shall utilize the procedures in this policy to obtain information, and shall confidentially submit the information to the Associate Vice President for Research and Compliance for further action. Except as required by law, no one shall disclose the name of anyone making a report of noncompliant conduct without the express consent of the person making the report.

**Notice of the Research Compliance Hotline Number**

The Associate Vice President for Research and Compliance shall provide a current notice of the Research Compliance Hotline number to all University vice presidents, deans, and department heads to be posted in noticeable locations for employees, students, and agents working in those locations.

**Procedures for Receiving Reports of Noncompliant Conduct**

All reports of noncompliant conduct shall be handled in a confidential manner, according to the following guidelines:

1. **Recording Information:** Persons receiving reports of noncompliant conduct shall use the Report of Noncompliant Conduct Information Sheet (Attachment A) to obtain the information necessary for investigating the complaint. The completed Report of Noncompliant Conduct Information Sheet shall be forwarded to the Associate Vice President for Research and Compliance, who shall maintain the confidential information in a secure location.
2. **Handling Calls to the Research Compliance Hotline:** Calls to the Research Compliance Hotline shall be handled by the Research Compliance Office. The following procedures are to be followed in answering a call to the Hotline:

   a. **Identification:** Callers shall be asked if they want to give their name, department, and contact telephone number. If a caller wishes to remain anonymous, they shall be allowed to do so.

   b. **Calls During University Business Hours (Monday–Friday, 8:00 a.m.–4:30 p.m.):** In most cases, calls to the Research Compliance Hotline during University business hours will be handled by the Associate Vice President for Research and Compliance. If the Associate Vice President for Research and Compliance is unavailable, the caller will have the option of either leaving a message on voice mail or contacting the Associate General Counsel (402-280-2107) to report any suspected noncompliant activity or conduct. A caller who chooses to contact the Associate General Counsel will have the option of remaining anonymous.

   c. **Calls Outside Regular Business Hours (including weekends and holidays):** During non-business hours, calls to the Research Compliance Hotline will be handled through the voicemail system for the Research Compliance Hotline. Hotline callers will be given three options:

      - To call back during business hours if they do not want to leave information on the voicemail system.

      - To leave their name and phone number or other contact information on the voicemail system. Callers who leave contact information will be contacted within a reasonable time, preferably the next business day.

      - To leave a voicemail message regarding the suspected noncompliant conduct or activity. Callers who leave a message regarding noncompliant conduct or activity should also leave contact information or should call back on the next business day to follow up on the report.
# Investigating Reports of Noncompliant Conduct

Before initiating investigation of any report of noncompliant conduct, the Associate Vice President for Research and Compliance shall contact the General Counsel’s Office. The General Counsel’s Office shall decide whether or not to oversee any investigation. If the General Counsel’s Office decides not to oversee the investigation, then the Associate Vice President for Research and Compliance shall be primarily responsible for conducting or supervising the investigation. In most cases, the Associate Vice President for Research and Compliance will forward anonymous Research Compliance Hotline reports to the appropriate University research oversight committee, board, or office for further investigation and action according to its policies and procedures for addressing noncompliance. The written results of such investigations, including any corrective action taken or recommended, shall be given to the Associate Vice President for Research Compliance.

After receiving the written investigation results, the Associate Vice President for Research and Compliance shall ensure that appropriate corrective action, if any is required, has been taken or is implemented. The Associate Vice President for Research and Compliance, in consultation with the General Counsel’s Office, shall determine if any government or private funding agency must be notified prior to, during, or after any investigation. If the noncompliance must be reported to a federal regulatory agency and organizational officials, the Associate Vice President for Research and Compliance, in consultation with the General Counsel’s Office, shall report the noncompliance to the appropriate federal regulatory agency and organizational officials in the time frame required by the agency or within 30 days, whichever is shorter.

### V. ADMINISTRATION AND INTERPRETATIONS

Questions regarding this policy may be addressed to the Associate Vice President for Research and Compliance or the General Counsel.

### VI. AMENDMENTS OR TERMINATION

This policy may be amended or terminated at any time.
REPORT OF NONCOMPLIANT CONDUCT
INFORMATION SHEET

Date: _____________________  Time (if applicable): ______________________

Reporter’s name (optional and confidential): ______________________________________

Reporter’s department (optional and confidential): __________________________________

Reporter’s phone number (optional and confidential): _____________________________

Report received and recorded by: ________________________________________________

Method of contact:

☐ Telephone, Research Compliance Hotline  ☐ E-mail
☐ Telephone, other  ☐ Other ______________________
☐ In person

Information to obtain from reporter:

a. Name(s) and department of individuals involved in alleged noncompliance: _______
   _________________________________________________________________
   _________________________________________________________________
   _________________________________________________________________

b. Description of suspected noncompliance, including date(s) and location(s), as applicable:
   _________________________________________________________________
   _________________________________________________________________
   _________________________________________________________________

   c. Name(s) of any other persons who may have knowledge regarding this matter
      (to remain confidential for purposes of investigating the alleged misconduct): _______
      _________________________________________________________________
      _________________________________________________________________
      _________________________________________________________________

   d. Has the suspected noncompliant conduct been reported to
      anyone else?  ☐ Yes  ☐ No

   e. If Yes, obtain the following information:

      1. Name of person(s) reported to: _____________________________________________
      2. Date the report was made: _______________________________________________
      3. Was the report written or oral? ___________________________________________
f. Can the reporter provide any documentation to assist in an investigation?  
☐ Yes  ☐ No

g. Is the reporter willing to meet with the Associate Vice President for Research and Compliance and/or the chair of the associated regulatory committee?  
☐ Yes  ☐ No

The following is to be completed by the Associate Vice President for Research and Compliance.

This report has been received by and/or forwarded to the following (check all that apply) for investigation and follow-up:

☐ Associate Vice President for Research and Compliance
☐ Research Compliance Committee
☐ Institutional Review Board
☐ Institutional Animal Care and Use Committee
☐ Institutional Biosafety Committee
☐ Radiation Safety Committee
☐ Campus Safety Committee
☐ Grants Administration
☐ Controller’s Office
☐ General Counsel’s Office
☐ Internal Audit Department

The Associate Vice President for Research and Compliance shall attach information related to investigation, follow-up, and any disciplinary action taken.

Date investigation and file closed: ________________________________
Policies and Procedures

SECTION: Administration

CHAPTER: General

POLICY: Crisis Plan

PURPOSE

In crisis situations the Crisis Plan will better enable the University to protect and support students, faculty, staff and visitors; enhance the University’s ability to communicate with internal and external constituents; enhance the ability of the University to quickly recover from loss or damage to facilities, equipment or grounds; facilitate the continuation of University business operations and/or University business recovery procedures; assure compliance with regulatory requirements of Federal, State and local agencies; and enable the University to utilize multi-perspective approaches in an organized manner to generate creative problem-solving solutions in a crisis.

POLICY

A Crisis Management Team (CMT) will meet when a crisis occurs. The CMT will normally be composed of the following individuals (or their designees):

Director of Public Relations
Director of Public Safety
Director of Facilities Management
General Counsel, or designee
Vice President of affected area, or designee
Vice President for Information Technology, or designee
Vice President for Student Life, chair
Vice President for Support Services, Creighton University Medical Center/Saint Joseph Hospital
Vice President for University Ministry, or designee

Other individuals may be asked to serve on a particular CMT, based on the nature of the crisis. Examples of individuals would include representatives of Residence Life, Counseling and Psychological Services, Student Health, Student Financial Aid, Multicultural Affairs, Human Resources, International Programs, Student Center, Campus Recreation, Risk Management, Academic Affairs, Environmental Health and Safety, Facilities Maintenance, and the Creighton Student Union President.

SCOPE

This policy applies to all University faculty, staff and students.
DEFINITIONS

**Crises** typically involve catastrophic events, significant health/safety issues, threats to University operations, and/or the news media.

**Emergencies** are handled by established departmental policies and procedures.

**ADMINISTRATION AND INTERPRETATION**

1. The Vice President for Student Life will serve as chair of the CMT. When the Vice President for Student Life determines that an emergency is a crisis situation, the Vice President will contact members of the CMT regarding the need for an immediate meeting of the committee. Other members of the campus community may contact the Vice President for Student Life and request a meeting of the CMT. The Vice President will decide if the CMT needs to meet.

   The CMT will prepare the institution to deal with crisis situations and to manage crises when they occur. The preparation will entail the development of response plans at the University, divisional and departmental levels, scenario planning, training and identification of resources needed to implement the crisis plans.

   The management of a crisis will commence when a situation occurs that justifies calling together the CMT. The criteria to be used to determine when a situation is a crisis will be determined by the CMT.

2. **Crisis Response Teams (CRT)**

   The CMT may decide to organize one or more Crisis Response Teams to respond to crisis situations, where members of the team will attend to the people and the details of the situation. Response Teams will be composed of designated individuals, (e.g., Academic Affairs, University Ministry, Counseling, Residence Life, Student Services and/or Human Resources).
Policies and Procedures

SECTION: Administration

CHAPTER: General

POLICY: Crisis Plan

A CRT will respond to the scene of the crisis situation and to other sites where a coordinated response to the crisis is deemed necessary. They will attend to the human, logistical and physical needs of the situation. CRT’s will provide support for the immediate situation, relay information to the CMT and coordinate the follow-up of the situation after the immediate crisis has passed.

The CRT may call upon resource persons in other offices to assist with handling the immediate situation and/or with handling the follow-up to the situation. Examples of such offices include University Ministry, Student Activities, Center for Service and Justice, Student Financial Aid, Bookstore, Student Center, Career Services and Campus Recreation.

AMENDMENT

The University reserves the right to modify, amend or terminate this policy at any time.

OTHER

Location: The primary location for the CMT to meet will be in Brandeis Hall, room 111. The back-up location for crisis meetings will be determined by the CMT from among conference rooms in the Skutt Student Center, Public Safety, Public Relations and Facilities Management.
I. PURPOSE

The purpose of this Policy is to fulfill the requirements of Section 6032 of the Deficit Reduction Act of 2005 by providing to Creighton University employees and employees of contractors or agents of the University detailed information on pertinent University policies and procedures and federal and state laws.

II. POLICY

In accordance with the requirements of federal law, the University will provide its employees and employees of contractors or agents of the University with detailed information about (1) the University’s policies and procedures for detecting and preventing fraud, waste and abuse with respect to federal health care programs, including Medicare and Medicaid; (2) federal and state laws that prohibit the submission of false claims for payment to federal health care programs such as Medicare and Medicaid, and (3) federal and state laws that provide protection to employees who bring action or assist in bringing action against their employers under the federal and state laws that prohibit the submission of false claims for payment.

III. SCOPE

This Policy applies to faculty, staff including student employees, fellows, and residents of the clinical departments of the School of Medicine; staff and other employees of Creighton Medical Associates; faculty, staff and other employees of the clinical departments of the School of Dentistry; faculty, staff and other employees of the clinical operations of the School of Pharmacy (i.e., the hospital outpatient pharmacy) and Health Professions; members of the University Subcommittee on Hospital and Health Affairs; the President’s Office; staff and other employees of Student Health; staff of the Internal Audit Department; staff of the Controller’s Office; staff of the Human Resources Department; staff of the General Counsel’s Office; and staff of the Purchasing Department. To the extent required by the Deficit Reduction Act of 2005, this Policy applies to employees of contractors and agents of the clinical departments of the School of Medicine, Creighton Medical Associates, the clinical departments of the School of Dentistry, and the clinical operations of the School of Pharmacy. The individuals to whom this Policy applies are hereinafter referred to as “Employees, Agents and Contractors.”

IV. PROCEDURE

The University, through its Health Sciences Schools, is involved in the delivery of health care services and items, some of which are paid for by Medicare and Medicaid. Through its Compliance Plan for Health Sciences Billing and Patient Services (the “Billing Compliance Plan,” discussed further below), the University seeks to prevent, detect and correct any noncompliant activity leading to fraud, waste and abuse in its delivery of health care services.
The federal government believes that individuals can play an important role in detecting and reporting noncompliant activity and thus preventing fraud, waste and abuse in federal health care programs, such as Medicare and Medicaid. The federal government has enacted a law to help individuals better understand their role in detecting and reporting noncompliant activity that leads to fraud, waste and abuse in federal health care programs. The law requires the University to provide information to Employees, Agents and Contractors on the laws that protect federal health care programs from fraud, waste and abuse. The law also requires the University to provide information to Employees, Agents and Contractors on the laws that protect individuals who detect and report noncompliant activity to the University or the government. Through this Policy, the University is providing the information required by law to its Employees, Agents and Contractors.

The University’s Billing Compliance Office and Office of General Counsel may provide training on this Policy as they determine necessary.

A. Creighton University’s Policies and Procedures for Preventing and Detecting Fraud, Waste and Abuse: The Compliance Plan for Health Sciences Billing and Patient Services

The University has adopted the Billing Compliance Plan to function as its policies and procedures for detecting and preventing fraud, waste and abuse with respect to health care programs, including Medicare and Medicaid. The Billing Compliance Plan includes provisions for compliance oversight, compliance reporting, standards of conduct, investigation of compliance concerns, screening of personnel, compliance training and education, monitoring and auditing, responses to noncompliance and enforcement. The Billing Compliance Plan is supported by additional separate compliance policies and procedures as adopted by the Health Sciences Schools. For further detail, please refer to the Billing Compliance Plan and its supporting policies and procedures, which can be found at: http://www2.creighton.edu/generalcounsel/billingcompliance/index.php

Under the Billing Compliance Plan, employees and agents of the University are provided with a mechanism for reporting to the University potential or actual noncompliant activity. The Billing Compliance Plan also states that employees and agents are required to make such reports to the University. The University prohibits retaliation against any employee who reports, in good faith, any potential or actual violation of the laws described in this Policy to the University or the government.

B. The Federal False Claims Act

The Federal False Claims Act, 31 U.S.C. § 3729 to § 3733 (the “FCA”), prohibits knowingly making a false claim against the government (for example, Medicare or Medicaid). In relevant part, the FCA provides civil liability for any person who:
Policies and Procedures

SECTION: Administration

CHAPTER: General

POLICY: False Claims Laws and Employee Reporting of Noncompliance

(1) knowingly presents, or causes to be presented, to the government a false or fraudulent claim for payment or approval;

(2) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the government;

(3) conspires to commit a violation of the FCA; or

(4) knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the government, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the government.

A bill for health care services submitted to Medicare or Medicaid by a hospital or physician is a claim filed with the government subject to the FCA. Examples of false claims include billing for services or supplies not provided, altering claim forms to obtain a higher payment amount, misrepresenting a diagnosis to justify the services or equipment furnished, or misrepresenting the services rendered, amounts charged for services rendered, identity of the person receiving or providing the services, dates of services, or frequency, duration or description of services. For the purposes of the FCA, “knowingly” is defined as actual knowledge that the information is false or fraudulent, acting in deliberate ignorance of the truth or falsity of the information or acting in reckless disregard of the truth of falsity of the information. Liability arises for those individuals who create and those individuals who submit the information on a false claim (even if the claim is not paid by the government). The government can enforce the FCA against both an organization and individual employees who commit billing fraud.

An organization or individual who is found to have committed any acts prohibited by the FCA may be fined a civil penalty of not less than $5,500 nor more than $11,000 per claim, plus three (3) times the amount of damages sustained by the government for each false claim. Penalties under the FCA may be reduced if an organization self-reports a false claim to Medicare or Medicaid within 30 days of discovering the false claim and cooperates with the government in investigating the false claim provided that there is no government action underway against the organization at the time it self-reports. In addition to penalties under the FCA, the organization or individual submitting a false claim may be subject to criminal prosecution, other monetary penalties and exclusion from federal and state healthcare programs, including Medicare and Medicaid.

The government may enforce the FCA against individuals or organizations directly. In addition, the FCA authorizes private citizens to (1) sue, on behalf of the government, organizations or individuals who have knowingly submitted false claims to the government; and (2) to share in any monetary proceeds recovered as a result of the suit.
 Law suits brought by private citizens are known as “qui tam actions” or “whistleblower suits.” If the government or an individual is going to bring an action against an individual or organization for violation of the FCA, the action must be brought within six years of the date of violation of the law or three years after the date when material facts are known or should have been known by the government about the violation of the law, whichever date is later.

**However, in no event can an action be brought for violation of the FCA more than ten years after the date on which the violation was committed.** If the government intervenes in a whistleblower suit, for statute of limitations purposes, the government can relate back to the filing date of the whistleblower’s suit.

The FCA also protects employees, agents and contractors who initiate or assist in qui tam actions from retaliation. These employees, agents and contractors are sometimes referred to as “whistleblowers”. Under the FCA, an employee, agent and contractor who is terminated, demoted, suspended, or in any way discriminated against because of his/her initiation of or assistance in a qui tam action has the right to sue for reinstatement, back pay and other damages.

**C. Program Fraud Civil Remedies Act**

The Program Fraud Civil Remedies Act, 31 U.S.C. §3801 to §3812 (the “PFCRA”), sets forth administrative procedures that address allegations of fraud against the government, including false claims against Medicare or Medicaid, when the amount of claims involved is less than $150,000. The PFCRA provides for additional administrative penalties for false claims that are distinct from the FCA.

Under the PFCRA, a person may not submit a claim that (1) is false, fictitious or fraudulent; (2) includes or is supported by a written statement which asserts a material fact which is false, fictitious or fraudulent; (3) includes or is supported by any written statement that omits a material fact, is false, fictitious or fraudulent as a result of such omission and the statement is a statement in which the person making, presenting or submitting such statement has a duty to include such material fact; or (4) is for payment for the provision of property or services which the person has not provided as claimed. A person who violates these provisions of the PFCRA may be subject to penalties in the amount of $5,500 for each claim and two times the amounts of claims submitted.

In addition, under the PFCRA, a person who makes, presents, or submits a written statement that the person knows or has reason to know (1) asserts a material fact which is false, fictitious or fraudulent; (2) omits a material fact and is false, fictitious or fraudulent as a result of such omission when the person has a duty to include such material fact; and (3) contains or is accompanied by an express certification or affirmation of the truthfulness or accuracy of the contents of the statement may be subject to a civil penalty of up to $5,500 for each such statement. Under the PFCRA, the government has up to six years after the false claim was submitted to impose penalties and it has up to three more years after it imposes penalties to bring an action in court to collect any penalties it imposes.
D. The Nebraska False Medicaid Claims Act

The Nebraska False Medicaid Claims Act, Neb. Rev. Stat. § 68-934 to §68-947 (the “Nebraska False Claims Act”), prohibits the same conduct that is prohibited by the FCA, as discussed above. The Nebraska False Claims Act also imposes civil liability on any person who:

1. When acting on behalf of a provider providing a good or service for which a claim is submitted to Medicaid, charges, solicits, accepts or receives anything of value in addition to the amount legally payable by Medicaid in connection with the provision of such good or service knowing that the charge, solicitation, acceptable or receipt is not legally payable; or

2. Having submitted a claim or received payment for a good or service under Medicaid, knowingly fails to maintain such records as necessary to fully disclose the nature of all the goods or services for which a claim was submitted or payment was received for a period of at least six years after the date on which the payment was received or knowingly destroys such records within six years from the date payment was received.

If an individual or organization is found to have violated the Nebraska False Claims Act, the person is subject to a civil penalty of not more than $10,000 per claim and damages in the amount of three times the amount of the false claim submitted to the state. In addition, the person must pay for the state’s costs and attorney’s fees incurred in bringing the action against the person and recovering the penalties or damages imposed. If an organization or individual self-reports a false claim to the state within 30 days of discovering the false claim, cooperates with the state and there is no government action underway against the organization or individual at the time of reporting, the penalties may be reduced.

All actions brought for violations of the Nebraska False Claims Act must be brought within six years of the date the claim is discovered or should have been discovered but in no event more than 10 years after the date the violation was committed. The Nebraska False Claims Act currently contains no qui tam action or whistleblower protection provisions.

V. ADMINISTRATION AND INTERPRETATION

Any question regarding this Policy can be directed to the Billing Compliance Office (280-2107) or the Office of General Counsel (280-5589).

VI. AMENDMENTS OR TERMINATION OF THIS POLICY

This Policy may be amended or terminated at any time.

VII. REFERENCES

**Policies and Procedures**

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<thead>
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<tr>
<td>POLICY: Document Retention and Destruction</td>
<td>REV. A</td>
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</table>

**PURPOSE**

The purpose of this policy is to establish a University-wide guideline and process for the retention and destruction of University records.

**SCOPE**

This policy applies to all Creighton University records, except as otherwise noted in this section. This policy does not apply to records that are protected under the Health Insurance Portability and Accountability Act (HIPAA) or records maintained for federal research/compliance/grants administration purposes. Please see Policy 2.4.44. “Documentation Policy” and Policy 2.4.27. “Media Disposal and Re-Use” for records that are protected under HIPAA and see: [http://www.creighton.edu/fileadmin/user/ResearchCompliance/Policy_Records_Retention_08apr2009.pdf](http://www.creighton.edu/fileadmin/user/ResearchCompliance/Policy_Records_Retention_08apr2009.pdf) for Retention of University Research and Compliance Records. This policy does not apply to records of students as maintained by those departments listed in the Student Records Policy, which can be found at: [http://www.creighton.edu/registrar/informationandschedules/confidentiality/index.php](http://www.creighton.edu/registrar/informationandschedules/confidentiality/index.php). The departments listed in the Student Records Policy are responsible for adopting their own guidelines as to retaining student records for which they have oversight.

**POLICY STATEMENT**

1. Creighton University is committed to managing University records in order to meet legal requirements, optimize use of space, minimize cost, and destroy outdated and unnecessary records. This Policy identifies certain records that must be retained for specific periods of time (see Attachment A). In addition, various departments and divisions throughout the University have developed, or are in the process of developing, record retention practices that are tailored to their specific functions.

2. A University record is any information which is created in the course of conducting University business. University records can be created and/or maintained in electronic or paper formats or as audiovisual materials.

3. As a general rule, and in the absence of any law or regulation requiring a specific retention period, University records should be retained for the period they are needed for business or academic reasons.
4. If the University is being investigated, prosecuted, sued or audited, or any person has reason to believe any University records will be requested by any federal, state or local government agency, then the person/department that becomes aware of such an investigation or prosecution shall immediately inform the Controller’s Office and the Office of General Counsel, and the following Preservation Notice procedures shall apply:

Creighton University has a legal obligation to preserve evidence and records, including electronically stored information, which might be relevant in any pending or potential claim or action, such as a government audit, administrative proceeding or lawsuit. When Creighton receives notice of a pending claim or litigation, the General Counsel’s office will send a preservation notice to potentially affected departments, as well as to the Division of Information Technology. Upon receipt of that notice, all records (paper and electronic) must be preserved. Any such preservation notice supersedes any other section of this Policy and any departmental or division document retention policy. No documents that are under a Preservation Notice may be destroyed, even if they are otherwise scheduled for destruction under this Policy or under a department policy.

**ROLES AND RESPONSIBILITIES**

1. The Controller’s Office is responsible for oversight of this Policy. The Office of the General Counsel, in conjunction with the Department of Information Technology, is responsible for oversight of the Preservation Notice process.

2. Department or division record retention policies should address: what to save; who will save it; where to save it; how long to save it and how to destroy it. Individual departments and divisions are responsible for managing records they maintain consistent with this policy. Departments and divisions should review and update their document retention policies periodically. Questions regarding this policy shall be directed to the Controller’s Office.

**DISPOSAL PROCEDURES**

1. If there is a prescribed retention period for a University record, and the retention period has expired, the University record should be properly disposed, so long as there is no Preservation Notice in effect. If there is no prescribed retention period and the University record is no longer needed for any business or academic reason, the University record may be disposed of, so long as there is no Preservation Notice in effect.
2. Confidential, sensitive or financial records must be shredded (if paper). Electronic documents and hard drives must be destroyed in accordance with procedures adopted by the Department of Information Technology. For questions regarding disposal of electronic information, please consult the Division of Information Technology for proper disposal methods.

AMENDMENTS AND TERMINATION OF THIS POLICY

The University reserves the right to modify, amend or terminate this policy at any time.

Resources

Attachment A

The following table provides the minimum requirements.

<table>
<thead>
<tr>
<th>Type of Document</th>
<th>Minimum Requirement</th>
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<tr>
<td>Accounts payable ledgers and schedules</td>
<td>7 years</td>
</tr>
<tr>
<td>Audit reports</td>
<td>Permanently</td>
</tr>
<tr>
<td>Bank reconciliations</td>
<td>2 years</td>
</tr>
<tr>
<td>Bank statements</td>
<td>3 years</td>
</tr>
<tr>
<td>Checks</td>
<td>7 years</td>
</tr>
<tr>
<td>Contracts</td>
<td>Permanently</td>
</tr>
<tr>
<td>Correspondence (general)</td>
<td>2 years</td>
</tr>
<tr>
<td>Correspondence (legal and important matters)</td>
<td>Permanently</td>
</tr>
<tr>
<td>Deeds, mortgages, and bills of sale</td>
<td>Permanently</td>
</tr>
<tr>
<td>Duplicate deposit slips</td>
<td>7 years</td>
</tr>
<tr>
<td>Employment records</td>
<td>3 years</td>
</tr>
<tr>
<td>Year-end financial statements</td>
<td>Permanently</td>
</tr>
<tr>
<td>Internal audit reports</td>
<td>10 years</td>
</tr>
<tr>
<td>Inventories of products, materials, and supplies</td>
<td>7 years</td>
</tr>
<tr>
<td>Invoices (to customers, from vendors)</td>
<td>7 years</td>
</tr>
<tr>
<td>Minute books, bylaws and charter</td>
<td>Permanently</td>
</tr>
<tr>
<td>Payroll records and summaries</td>
<td>7 years</td>
</tr>
<tr>
<td>Retirement and pension records</td>
<td>Permanently</td>
</tr>
<tr>
<td>Tax returns and worksheets</td>
<td>Permanently</td>
</tr>
<tr>
<td>Timesheets</td>
<td>3 years</td>
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<tr>
<td>Withholding tax statements</td>
<td>7 years</td>
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Policies and Procedures

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<tr>
<th>POLICY: Influenza Vaccination Requirement</th>
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PURPOSE

Influenza vaccination is the most effective method for preventing transmission of the influenza virus and its potentially severe complications. This policy has as its purpose to protect the health and well-being of faculty, staff, students, patients, families and the community at large.

POLICY

All University employees and students placed in health care settings or the University’s child development center are required to be vaccinated for influenza by December 1 of each year.

University employees will be offered the influenza vaccine at University cost during scheduled clinics. Students will be offered the influenza vaccine during student clinics sponsored by the Center for Health and Counseling.

SCOPE

All Creighton University faculty, staff, and students.

DEFINITIONS

Medical Contraindication: A contraindication is a condition in a recipient that increases the risk for a serious adverse reaction.

PROCEDURES

A. All University faculty, staff, and students shall be notified annually of the Creighton University Influenza Vaccination Requirements policy.
B. Influenza vaccinations will be administered in accordance with:
   a. National recommendations in effect at the time of vaccination
   b. Manufacturer guidelines for administration
C. If influenza vaccine supplies are not reasonably available, this policy may be suspended and/or the annual deadline may be extended.
D. The influenza vaccine will be provided at no cost to the faculty, staff, or student.
E. Healthcare and child care employees and students placed in clinical health care settings must receive their annual influenza vaccination no later than December 1st of each year.
a. New healthcare and child care employees and students placed in clinical health care settings, after December 1st, but before April 1st of each year shall have his or her status for influenza vaccination(s) determined at the time of hire/placement. If such individual has not had the influenza vaccination, the University shall arrange for the necessary vaccination at no cost to the new faculty/staff/student or he/she will arrange to receive the vaccination from a source other than the University, and will provide the University with proof of having received the vaccination.

F. The University will maintain annual influenza vaccination status documentation in an employee health or student health file for all healthcare and child care employees and students in a clinical health care setting.

G. Healthcare and child care employees and students in a clinical health care setting may decline (see attachment 1) the influenza vaccination for the following reasons:
   a. Documented medical contraindication according to the Guide to Contraindications to Vaccinations published by the CDC.
   b. Documented receipt of the vaccine from a source other than the University.
   c. Employees with a documented medical contraindication must wear an approved mask at all times at work during the influenza season.
   d. Any failure to comply with appropriate mask wearing will be viewed as a violation of the vaccination requirements, and will be seen as the employee’s decision to voluntarily resign from his/her position.

H. Employees who object to vaccination on religious grounds must complete the application request form (see attachment 2).
   a. If an application is approved, the individual must wear an approved mask at all times at work during the influenza season.
   b. Any failure to comply with appropriate mask wearing will be viewed as a violation of the vaccination requirement, and will be seen as the employee’s decision to voluntarily resign from his/her position.

I. After the effective date of this policy, prospective healthcare employees and child care employees will be informed that it is a condition of employment that they get an influenza vaccination annually.

ATTACHMENTS

1. Vaccination Declination Form
2. Vaccination Request Form for Religious Exemption
**Administrative Policy**

**SECTION:** Administration  
**NO.:** 2.1.23.  
**CHAPTER:** General  
**ISSUED:** 9/17/10  
**POLICY:** Influenza Vaccination Requirement  
**PAGE 3 OF 3**

**ADMINISTRATION AND INTERPRETATIONS**

This policy shall be administered by CMA Employee Health, the Division of Health Sciences, and Human Resources for employees. The Center for Health and Counseling will administer vaccinations for students. Employees’ questions regarding this policy should be directed to Creighton Human Resources. Students’ questions regarding this policy should be directed to their respective Dean’s Offices or where applicable, the Director of Creighton’s Child Development Center.

**AMENDMENT/TERMINATION OF THIS POLICY**

Creighton University reserves the right to modify, amend or terminate this policy at any time.

**REFERENCES**

Influenza Vaccination of Health-Care Personnel Recommendations of the Healthcare Infection Control Practices Advisory Committee (HICPAC) and the Advisory Committee on Immunization Practices (ACIP), 2006

Centers for Disease Control and Prevention – Guide to Vaccine Contraindications and Precautions, February 2009

**VIOLATIONS/ENFORCEMENT**

Violations of this policy may result in corrective action in accordance with University procedures.
Declination of the
Influenza Vaccination

Date: ___________________________ Department: ________________
Employee’s Name _______________________ Date of Birth: ________________

The Centers for Disease Control has recommended that I receive influenza vaccination in order to protect myself and the patients I serve.

I acknowledge that I am aware of the following facts:

▪ Influenza vaccination is recommended by the CDC for me and all other healthcare workers to prevent influenza disease and its complications, including death.
▪ If I contract influenza, I will shed the virus for 24 -48 hours before influenza symptoms appear. Shedding the virus can spread influenza infection to patients in this facility.
▪ If I become infected with influenza, even when my symptoms are mild, I can spread severe illness to others.
▪ I cannot get the influenza disease from the influenza vaccine.
▪ The consequences of my refusing to be vaccinated could endanger my health and the health of those with whom I have contact, including:
  ○ patients in this healthcare setting
  ○ my co-workers
  ○ my family
  ○ my community

I am choosing to decline influenza vaccination for the following reason:

☐ I have a medical contraindication (documentation attached), according to the Guide to Contraindications to Vaccinations published by the CDC

☐ I have already received the influenza vaccine for this season from another health care provider (documentation attached).

I understand that I will be required to wear an approved mask at all times at work during the influenza season.

I understand that any failure to comply with appropriate mask wearing will be viewed as a violation of the vaccination requirement and shall be seen as my decision to voluntarily resign from my position.

I have read and fully understand the information on this declination form.

Signature: ___________________________ Print Name: ___________________________

Witness Signature ___________________________ Print Name: ___________________________
REQUEST FOR EXEMPTION FROM INFLUENZA VACCINATION FOR RELIGIOUS REASONS

Employee’s Name: _________________________________________________________

Position: __________________________________________________________________

Department: ________________________________________________________________

By signing below, I state and affirm that I am refusing to get an influenza vaccine for religious reasons. I understand that I must provide a written statement signed by an authorized representative of the religion of which I am a member, identifying the conflicting religious doctrine that prevents me from being vaccinated.

I understand that if my request is granted, I must wear a mask (in accordance with CDC guidance) at all times while I am in the workplace. My failure to do so shall be seen as my decision to voluntarily resign from my position.

______________________
Employee’s Signature

_______________________
Date

ATTESTATION

The undersigned, being the ________________ (title) of the _______________________________ (name of religious organization), does hereby state and attest that the employee named above is a member of this religious organization. In our religious tradition, receiving an influenza vaccination would violate the following religious doctrine/principle of our faith:

___________________________________________________________________________________________

___________________________________________________________________________________________

____________________________________________ ____________________________________________

_________________________
Signature

__________________________
Printed Name and Title

This form must be returned to CU Human Resources Attn: ___________________________

Request: Approved___________

Denied __________
Policies and Procedures

SECTION: Administration

CHAPTER: General

POLICY: Travel Warning Policy

PURPOSE
Creighton University recognizes the value of international learning and service activities. At the same time, Creighton acknowledges the potential risks which participants in international experiences may encounter, and monitors conditions that could adversely affect the health, safety and security of members of the Creighton community who wish to travel internationally. The University's policy on trips outside of the United States is set forth below.

POLICY
Creighton University will not permit members of the Creighton community who are using Creighton resources or representing Creighton in any way to travel abroad to a country which is under either a Centers for Disease Control ("CDC") Travel Health Warning or a U.S. Department of State Travel Warning, or which has an unacceptable safety rating according to Creighton’s insurance carrier. Insurance carrier travel ratings can be obtained by contacting the Creighton University Risk Management Office at 280-5833.

A CDC Travel Health Warning is issued when there is a widespread, serious outbreak of a disease of public health concern.

A State Department Travel Warning means the State Department has decided, based on all relevant information, to recommend that Americans avoid travel to a certain country.

If a trip has been approved for travel to a location that becomes the subject of an active travel warning before the participants depart, the trip will be cancelled. Creighton University will take steps to withdraw participants from a country if a travel warning is declared for that country.

The State Department may also issue a travel alert as a way to disseminate information about terrorist threats and other relatively short-term and/or trans-national conditions posing significant risks to the security of American travelers. While trips to countries for which a travel alert has been issued are not always prohibited, Creighton University reserves the right to cancel a planned trip, or withdraw participants from a country, in the event a travel alert is issued for a particular country if the alert indicates a special danger for the trip.

PROCEDURES
The Office of the Vice President for Student Life, the Office of International Programs and the relevant Dean’s office, must be notified in advance of any Creighton trips to foreign countries involving Creighton students. These trips may include, but are not limited to: service trips, presentations/attendance at conferences, and intramural/club/organization tournaments. University affiliated trips are defined as those in which a Creighton delegation/group/team/organization is attending, if university or student fees are utilized, and/or the Creighton name will be used during the trip.
The Office of International Programs must be notified in advance of Creighton trips involving faculty or staff members. Faculty members should also advise their Dean’s office of their travel plans.

The Vice President of the division in which the travel is administered will make decisions regarding travel in his or her division, with input from the Risk Manager, Office of International Programs, and other persons with subject matter expertise.

Members of the Creighton community must be aware of the conditions they may encounter when they travel internationally. Creighton University strongly recommends that all persons seeking to travel internationally check the US State Department website before they depart. Travelers may register their trip with the State Department at [http://travel.state.gov](http://travel.state.gov). Creighton University also recommends that travelers review the CDC site at [http://wwwnc.cdc.gov/travel](http://wwwnc.cdc.gov/travel).

Use of Creighton University’s travel management company is encouraged for all travel, and particularly for international destinations. Travel assistance services are available 24/7 for reservations made through the travel management company. Visit the Purchasing website link [www.creighton.edu/purchasing](http://www.creighton.edu/purchasing) for more information on the travel service.

**AMENDMENTS OR TERMINATION OF THIS POLICY**

Creighton University reserves the right to modify, amend, or terminate this policy at any time.
Policies and Procedures

SECTION: Administration
NO. 2.1.25.

CHAPTER: General
ISSUED: 3/13/13
REV. A
REV. B

POLICY: Harassment, Discrimination and Grievances
PAGE 1 OF 8

PURPOSE

In accord with its history, mission and credo, Creighton University believes that each individual should be treated with respect and dignity and that any form of harassment and/or discrimination is a violation of human dignity. The University condemns harassment and discrimination and maintains a “zero-tolerance” for harassment and/or discrimination. Students, faculty, and staff have the right to work and learn free of harassment and discrimination. The University will take all reasonable efforts to prevent and promptly correct instances of harassment or discrimination. Additionally, students, faculty and staff have the right to a structured process for resolving problems, complaints or grievances relating to the execution of institutional policies.

The purpose of this policy is:

a. To communicate the mechanisms for investigating complaints in a manner that reasonably protects the privacy of individuals involved in situations of alleged harassment and/or discrimination and grievances;
b. To ensure the provision of equal employment and educational opportunities to faculty, staff, students and applicants for such opportunities without regard to race, color, religion, sex, marital status, national origin, age, disability, citizenship, sexual orientation, veteran status, and any other groups protected by federal, state or local statutes;
c. To protect all those involved who report or provide information related to harassment, discrimination, and/or grievances from retaliation of any kind;
d. To set forth guidance for preventing harassment and/or discrimination;
e. To take timely corrective action when harassment and/or discrimination is alleged to have occurred;
f. To ensure that students, faculty and staff have the opportunity to present grievances to the University regarding a certain action(s) perceived to be in violation of institutional policies by a member of the University community; and
g. To establish a consistent process for resolving complaints of harassment and/or discrimination and grievances in a fair and just manner.

POLICY

It is the policy of the University to provide equal employment and educational opportunities to faculty, staff, students and applicants without regard to race, color, religion, sex, marital status, national origin, age, disability, citizenship, sexual orientation, veteran status, and any other groups protected by federal, state or local statutes. In addition, it is the policy of the University to comply with applicable state statutes and local ordinances governing nondiscrimination in employment and educational activities. It is also the policy of the University to address grievances that are perceived to be in violation of an institutional policy that are not governed by other specific grievance procedures. Upon notification, The Office of Equity and Inclusion will determine if an investigation is warranted, enabling the office to investigate and to take corrective action where appropriate.
A member of the University’s community who believes himself or herself to be victim of harassment and/or discrimination is encouraged to report the information to The Office of Equity and Inclusion. The University requires all faculty and exempt staff to report any information they learn about discriminatory harassment, sexual harassment, discrimination, or sexual misconduct to the Office of Equity and Inclusion (see Mandatory Reporters Policy 2.1.26). The University encourages non-exempt staff and students to report all instances of harassment and discrimination.

The University will broadly disseminate this policy and distribute a list of resources available to respond to grievances, as well as concerns of harassment and/or discrimination. Additionally, the Violence Intervention and Prevention Center will develop and present appropriate educational programs for students, faculty, and staff. Creighton University will make every effort to stop harassment and discrimination before such incidents rise to the level of a violation of federal law.

**SCOPE/ELIGIBILITY**

This policy applies to all faculty, staff, and students of the University community. Non-university employees, including vendors, independent contractors, and other outside parties who conduct business with the University through affiliation and other agreements will be expected to comply with this policy as well, as specified by the terms of any contract or agreement between the University and such third party.

Additionally, this policy applies to all terms and conditions of employment including, but not limited to, hiring, placement, benefits, promotion, termination, layoff, recall, transfer, leaves of absence, compensation and training.

This policy also applies to all incidents of alleged harassment and/or discrimination, including those which occur off campus or outside of normal work, class or business hours, where the alleged incident involves a member of the University community and a supervisor, co-worker, faculty member, student, or non-University employee.

**DEFINITIONS**

- **Complainant.** An individual who is subject to alleged discrimination, harassment, retaliation, or unfair treatment regarding the interpretation or application of an existing University policy.
- **Respondent.** An individual whose alleged conduct is the subject of a complaint.
- **Discrimination.** Any distinction, preference, advantage for or detriment to an individual compared to others that is based upon an individual’s actual or perceived race, color, religion, sex, marital status, national origin, age, disability, citizenship, sexual orientation, veteran status, and any other groups protected by federal, state or local statutes. The conduct must be so objectively offensive as to alter the conditions of the individual’s employment or educational experience.
Policies and Procedures

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- **Discriminatory Harassment.** Detrimental action based on an individual’s actual or perceived race, color, religion, sex, marital status, national origin, age, disability, citizenship, sexual orientation, veteran status, and any other groups protected by federal, state or local statutes that is so severe, persistent or pervasive that it unreasonably interferes with or limits an individual’s ability to participate in or benefit from the work or educational environment. Examples of harassment include, but are not limited to, intimidation and humiliation as expressed by communications, threats, acts of violence, hatred, abuse of authority, or ill-will that assault an individual’s self-worth. Harassment of a non-sexual nature can include slurs, comments, rumors, jokes, innuendoes, cartoons, pranks and other verbal or physical conduct, frequent, derogatory remarks about women even if the remarks are not sexual in nature and any other conduct or behavior deemed inappropriate by Creighton University.

- **Sexual Harassment.** Unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature constitute sexual harassment where: (1) submission to such conduct is made either explicitly or implicitly a term or condition of an individual’s employment, (2) submission to or rejection of such conduct by an individual is used as the basis for employment decisions affecting such individual, or (3) such conduct has the purpose or effect of unreasonably interfering with an individual’s work performance or creating an intimidating, hostile, or offensive working environment.

- **Sexual Misconduct.** Include any unwanted kissing, any unwanted touching of an intimate part of another person, such as a sexual organ, breast, or buttocks as well as forced or non-consenting sexual intercourse. In this definition, sexual intercourse is defined to include sodomy, oral copulation, and rape by foreign object (penetration of genital or anal openings by a foreign object, including a finger). Additional information and definitions.

- **Retaliatory Harassment.** Intentional action taken by an accused individual or allied third party that harms a complainant, witness, reporter or any other individual for filing or participating in a University investigation.

- **Hostile Environment.** Harassment that is sufficiently pervasive as to alter the conditions of employment or the educational environment and create an abusive environment in which to work or study. The person alleging a hostile environment must show a pattern or practice of harassment against him or her; a single incident or isolated incidents generally will not be sufficient. In determining whether a reasonable person in the individual’s circumstances would find the work or educational environment to be hostile, the totality of the circumstances must be considered.

- **Grievance.** An issue of dispute that involves interpretation or application of an existing University policy.

- **Mandatory Reporter.** All faculty and exempt staff are required to report acts of discrimination, discriminatory harassment, sexual harassment, sexual misconduct, and crimes, and concerning and/or disruptive student behaviors. All non-exempt staff and students are strongly encouraged to report concerning behaviors, discrimination, discriminatory harassment, sexual harassment and crimes (see Mandatory Reporters Policy 2.1.26.).
Policies and Procedures

SECTION: Administration

NO. 2.1.25.

CHAPTER: General

ISSUED: 3/13/13  REV. A  REV. B

POLICY: Harassment, Discrimination and Grievances

PAGE 4 OF 8

PROCEDURES

a. General:

i. **Inquiries.** For the purpose of obtaining information about reporting any instance of harassment and/or discrimination, any individual may consult with the Office of Equity and Inclusion.

ii. **Education.** The University will broadly disseminate this policy and distribute a list of resources available to respond to grievances, as well as concerns of harassment and/or discrimination based on race, color, religion, sex, marital status, national origin, age, disability, citizenship, sexual orientation, veteran status, and any other groups protected by federal, state or local statutes. Additionally, The Violence Intervention and Prevention Center will develop and present appropriate educational programs for students, faculty, and staff.

iii. **Annual Report.** The Office of Equity and Inclusion shall maintain an annual report documenting the number of complaints received pursuant to this policy, the categories of those involved in the allegations, the number of violations found, and examples of sanctions/corrective actions imposed for policy violations.

iv. **Administrative Review:** In the absence of a formal complaint, the Office of Equity and Inclusion has the authority to initiate an administrative review at the request of a department, division, program, or area when in the requested by a manager, supervisor, director, department chair, dean, vice president, or provost or when in the judgment of the Office of Equity and Inclusion a review is necessary. As necessary the University reserves the right to serve as complainant and to initiate an investigation without a formal complaint.

v. **Resolution Options Outside of the University.** The University encourages any member of the University community who feels he or she has been subjected to harassment or discrimination to use the complaint procedure outlined in this policy. Additionally, an individual has the right to file a complaint with outside enforcement agencies:

a. **Filing a Complaint with an Outside Agency.** An individual also has the right to file a complaint with outside enforcement agencies including the United States Department of Education’s Office of Civil Rights, the Equal Employment Opportunity Commission (EEOC), the Nebraska Equal Opportunity Commission (NEOC), Nebraska Department of Labor, and City of Omaha Office of Human Rights and Relations, or state or local law enforcement or prosecution authorities.

b. Students located in Arizona may file a complaint with the Arizona State Board of Private Postsecondary Education. The student must contact the State Board for further details. The State Board address is 1400 W. Washington Street, Room 260, Phoenix, AZ 85007, phone 602-542-5709, website address: [www.azppse.gov](http://www.azppse.gov).

c. In the event a student located in any other state wishes to file a complaint with their state agency a listing of all state boards can be found [here](http://www.azppse.gov).

d. For additional information on resolution options outside of the University an individual may contact the Violence Intervention and Prevention Center.

e. Additionally, individuals may file a civil law suit against the offending party.
vi. Retention of Records. All records of grievance, harassment, discrimination, and discriminatory retaliation reports and investigations will be private and confidential to the greatest extent possible and will not be publicly disclosed except to the extent required by law. However, no member of the University’s staff or faculty, or any student is promised strict or absolute confidentiality. Additionally, all records will be retained for a minimum of seven years. When the respondent is a student, records will be retained according to the Retention of Disciplinary Record and Record Check Policy in The Creighton University Student Handbook.

vii. Anti-retaliation. The University expressly prohibits any form of retaliatory action against any individual for filing a bona fide complaint under this Policy or for assisting in a complaint investigation.

viii. False Reporting. The University encourages anyone who believes that s/he has been the victim of harassment or discrimination to report her/his concerns but will not tolerate intentional false reporting of incidents.

ix. Complaint Resolution. The investigation of any complaint of harassment, discrimination or grievance will determine if this Policy was violated. Additionally, the investigative report may address other serious issues disclosed during the course of the investigation and make recommendations to the appropriate University department or official for resolution.

x. Conflict of Interest. In the formal resolution process, if a member of the investigative team or the appropriate University authority has an actual or perceived conflict of interest, the investigator or appropriate University authority may be asked to excuse himself/herself from the process or the investigator or appropriate University authority may ask to excuse himself/herself from the process. The excused individual shall not have access to any of the materials for the case from which the individual is excused.

b. Informal Resolution:
   An option available to students, faculty and staff is to seek resolution informally. The University does not require an individual to contact the person directly whose behavior is unwelcome. Mandatory reporters should always contact The Office of Equity and Inclusion prior to any attempt to resolve a complaint.
   i. One-on-One Communication:
      a. If an individual is comfortable dealing with the situation without direct involvement of a third party, the individual can communicate directly with the person whose behavior is unwelcome. It is appropriate to use face-to-face communication only when the individual does not feel threatened, there is no risk of physical harm and you believe the other person will be receptive.
      b. Email/written correspondence is the preferred method of communication. If the individual chooses to communicate face-to-face, s/he should also send an email summarizing the face-to-face interaction. Keep copies of any written communication.
   c. One-on-One Communication should include:
      1. A factual description of the incident(s) including a description of the unwelcome behavior, date, time, place, and the names of any witnesses.
      2. A description of any consequences that the individual has experienced due to the unwelcome behavior.
3. A request for the unwelcome behavior to cease.
4. If the individual does not feel comfortable with the one-on-one communication or if the individual believes that the communication was not successful, the individual should consider other informal or formal procedures.

ii. Third Party Assistance. If an individual desires the assistance of a third party to attempt to resolve the situation informally, the individual may approach any one of the following resources:
   a. The Office of Equity and Inclusion
   b. The Center for Student Integrity (student)
   c. Human Resources (faculty and staff)
   d. The individual’s supervisor or the supervisor’s supervisor (faculty, staff & student employees)

All faculty, staff and students are strongly encouraged to report any actions or behaviors believed to be in violation of this policy. Allegations of harassment and discrimination that come to the attention of faculty and exempt staff must be reported. See Mandatory Reporter Policy 2.1.26. for additional information.

If the situation is not able to be resolved informally or if the individual chooses not to engage in an informal resolution, the individual may initiate a formal complaint using the procedures below.

**c. Formal Resolution:**
In all cases of an allegation of harassment, discrimination, and/or grievance, the individual(s) making such allegation may choose to bypass the informal resolution options and to proceed to a formal resolution. In the event that an informal resolution of the allegation of harassment, discrimination, and/or grievance is not resolved to the satisfaction of the individual(s) making the allegation, the person(s) alleging such harassment, discrimination, and/or grievance may submit a formal written complaint to The Office of Equity and Inclusion.

i. The written complaint shall set forth in reasonably sufficient detail the nature of the alleged harassment and/or discrimination, the individual(s) against whom the complaint is made, the name(s) of any witnesses, and any available evidence or sources of evidence. See Harassment, Discrimination and Grievance Complaint Form.

ii. Upon receipt of a written complaint, The Office of Equity and Inclusion shall first determine whether or not the written complaint states a potential violation of the Harassment, Discrimination and Grievance Policy or federal and state laws. The Office of Equity and Inclusion will notify the complainant in writing of its decision within five working days.

iii. If there is the potential of a violation of the Harassment, Discrimination and Grievance Policy or federal and state laws, The Office of Equity and Inclusion will assign an investigation team from its pool of trained investigators to conduct a prompt, thorough, and impartial investigation.

iv. The investigation team will objectively gather and consider relevant facts. The investigation team will ensure that statements of the complainant, the respondent, and all witnesses are documented and that the investigation is conducted in a thorough, objective manner and is considerate of the rights and emotions of all of the parties involved.
v. Upon assignment to an investigation team, the investigation will normally be concluded within 30 working days. The complainant and respondent will be notified in writing of any delays.

vi. The investigation will be private and confidential to the greatest extent possible. However, no member of the University’s staff or faculty, or any student is promised strict or absolute confidentiality. The investigation team will submit a written investigative report, including the findings of the investigation and a recommendation for action, based on a preponderance of evidence, to the Associate Vice President for Equity and Inclusion. In consultation with the appropriate University authority, the Associate Vice President for Equity and Inclusion will make a decision on the action, if any, to be taken.

   a. The appropriate University authority in matters involving complaints where the respondent is a student is the Vice Provost for Student Life.

   b. The appropriate University authority in matters involving complaints where the respondent is a member of the faculty reporting to him/her is the Dean of the College or School of the respondent.

   c. The appropriate University authority in matters involving complaints where the respondent is a member of the staff is the Associate Vice President for Human Resources.

   d. Additionally, the Associate Vice President for Equity and Inclusion may also consult other University officials in order to make a determination.

vii. In all cases of formal allegations of harassment, discrimination and/or grievance, a summary of the findings and recommendations shall be available for review by the complainant, the respondent, and to the appropriate University authority.

viii. The Associate Vice President for Equity and Inclusion will accept or reject the findings and/or recommendations of the investigative report using a preponderance of evidence standard.

ix. The Associate Vice President for Equity and Inclusion will communicate the decision to the complainant, to the respondent, and to the appropriate University authority within five working days. The University will take immediate and corrective action if appropriate.

d. Appeal

i. The complainant or respondent may appeal the decision made by the Associate Vice President for Equity and Inclusion for one or more of the following grounds:

   a. The decision made is arbitrary or capricious,

   b. If the decision is clearly unsubstantiated by the evidence, or

   c. If new information is presented that was not available during the course of the investigation.

ii. The written appeal must be filed within five working days after receiving the written decision with one of the following University authorities:

   a. The Provost will review all appeals involving complaints where the respondent is a student or a faculty member.

   b. The Senior Vice President will review all appeals involving complaints where the respondent is a staff member.

iii. The final determination will be made by the Provost or the Senior Vice President, using a preponderance of evidence standard within five working days upon receiving the written appeal.
### Policies and Procedures

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iv. The decision will be communicated to the complainant, respondent, and the Associate Vice President for Equity and Inclusion and shall be considered final.

### AMENDMENTS OR TERMINATION OF THIS POLICY

Creighton University reserves the right to modify, amend, or terminate this policy at any time.
**Policies and Procedures**

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**POLICY: Mandatory Reporters**

**PURPOSE**

The purpose of this policy is to articulate Creighton University’s expectation for all faculty and exempt staff of their mandated reporting responsibilities of concerning and disruptive behaviors, discrimination, discriminatory harassment, sexual harassment, sexual misconduct, and crimes. There are three federal laws that establish responsibilities for Creighton faculty and staff to report certain types of crimes and incidents, especially sexual misconduct—the Clery Act, Title VII and Title IX. Each of these areas of federal law has a different purpose, but generally the laws are intended to protect members of the campus community, visitors and guests from criminal and discriminatory behavior. Reporting of concerning and disruptive behaviors is not legally mandated, but is a policy mandate to assist the University in early identification and detection of threatening or at-risk situations. Additionally, state law requires the reporting of child abuse.

All other individuals are strongly encouraged to report concerning behaviors, discrimination, sexual harassment and crimes.

**POLICY**

It is the policy of the University to define all faculty and exempt staff as mandatory reporters. If a mandatory reporter learns about sexual harassment, discrimination or sexual misconduct, s/he is expected to promptly contact the Office of Equity and Inclusion. The Office of Equity and Inclusion will take responsibility for prompt notification of the Department of Public Safety and other appropriate University officials. Other serious crimes covered by the Clery Act must be reported to the Department of Public Safety. All concerning and disruptive student behaviors must be reported to the Office of the Vice President for Student Life. Concerning and disruptive employee (faculty or staff) behaviors must be reported to Human Resources. All behaviors by students, faculty or staff that are immediate and are an emergency should be reported to the Department of Public Safety at (402) 280-2911.

When reporting sexual harassment or discrimination or sexual misconduct, a mandatory reporter may initially be able to omit personally identifiable information (the name of the victim, the name of the accused individual, and other identifying details about witnesses, location, etc.). The Office of Equity and Inclusion can provide mandatory reporters with assistance regard to how much detail is needed in an initial report. Subsequent to an initial report, campus officials may need additional information in order to fulfill the University’s obligations under Title IX.
In taking these subsequent actions, the University will always be guided by the goals of empowering the victim and allowing the victim to retain as much control over the process as possible, but no individual (except healthcare providers and counselors in accordance with their code of ethics and state and federal law and clergy during the rite of confession) can or should promise confidentiality. Counselors, health service providers and clergy are voluntary reporters, not mandated by law, but University policy creates an expectation to report non-personally identifiable information.

The Clery Act requires reporting of 15 serious crimes, including sexual assault. Sexual harassment and discrimination are not covered by the Clery Act, but reporting of such incidents is required under Title IX. Mandatory reporters are expected to report crimes covered by the Clery Act to the Department of Public Safety without delay.

The Clery Act does not establish an obligation for Public Safety to conduct an investigation of the reported crime, only to report the crime as a statistic following Clery Act guidelines. In some cases, Public Safety may also be required to release a timely warning to the community about a threat to the community. In such cases, an initial investigation or determination of the nature of the threat may be conducted, after which a warning will be issued immediately.

Student behaviors that might be considered concerning or disruptive should be reported to the Office of the Vice President for Student Life. Based on the information provided a course of action will be determined and follow-up will be coordinated in collaboration with, but not limited to Student Counseling Services, the Department of Public Safety, and the impacted school/college. Determination in each student case will be made and, if needed, an agreed upon support plan will be created.

**SCOPE/ELIGIBILITY**

This policy applies to all University faculty and exempt staff. Vendors, independent contractors, and other outside parties who conduct business with the University will be expected to comply with this policy as well, as specified by the terms of any contract between the University and such third party.

This policy also applies to all incidents of alleged sexual harassment, discrimination or sexual misconduct, including those which occur off campus or outside of normal work, class or business hours, where the alleged incident involves a member of the University community and a supervisor, co-worker, faculty member, student or non-University employee.
### Policies and Procedures

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## PROCEDURE

1. The University has defined all faculty and exempt staff as mandatory reporters.
   a. When a mandatory reporter becomes aware of an alleged act of sexual harassment, discrimination or sexual misconduct, the mandatory reporter must promptly contact the Office of Equity and Inclusion. The mandatory reporter should use The Harassment and Discrimination Reporting Form. Alternatively, the employee may call the Office of Equity and Inclusion and then follow-up by filing the form.
   b. The Office of Equity and Inclusion will promptly inform the Department of Public Safety about the report if there are concerns about individuals and their safety.
   c. If a mandatory reporter thinks that an individual may be about to disclose an act of sexual harassment, discrimination or assault, the mandatory reporter should, if at all possible, tell the individual that the University will maintain the privacy of the information, but the mandatory reporter cannot maintain complete confidentiality and, is required to report the act and may be required to reveal the names of the parties involved. If the individual wishes to proceed, the mandatory reporter should inform the individual of the implications of sharing the names of the parties involved, which puts the University on notice?
      i. When the individual is a student, rather than speaking to the student about confidential information, the mandatory reporter should offer to refer or accompany the student to the Center for Health and Counseling for health and/or counseling services.
      ii. Individuals can be referred to the Associate Director for Violence Prevention and Education for support services and information.
      iii. The Women’s Center for Advancement Hotline (402) 345-7273 is available at any time of the day or week and provides immediate emotional support for victims and their families of sexual assault and/or domestic violence.
   d. The Office of Equity and Inclusion is also available to provide guidance on how to handle a situation.

2. Under the Clery Act, University faculty and exempt staff are mandatory reporters for a broader array of serious crimes.
   a. These crimes include the following:
      i. Murder & Non-Negligent Manslaughter--The willful killing of one human being by another.
      ii. Negligent Manslaughter--The killing of another person through gross negligence.
      iii. Robbery--The taking or attempting to take anything of value from the care, custody, or control of a person or persons by force or threat of force or violence and/or by putting the victim in fear.
iv. **Aggravated Assault**--An unlawful attack by one person upon another for the purpose of inflicting severe or aggravated bodily injury. This type of assault usually is accompanied by the use of a weapon or by means likely to produce death or great bodily harm. (It is not necessary that injury result from an aggravated assault when a gun, knife, or other weapon is used which could and probably would result in serious personal injury if the crime were successfully completed.)

v. **Burglary**--The unlawful entry of a structure to commit a felony or a theft. For reporting purposes this definition includes: unlawful entry with intent to commit a larceny or felony; breaking and entering with intent to commit a larceny; housebreaking; safecracking; and all attempts to commit any of the aforementioned.

vi. **Motor Vehicle Theft**--The theft or attempted theft of a motor vehicle. (Classify as motor vehicle theft all cases where automobiles are taken by persons not having lawful access even though the vehicles are later abandoned, including joyriding.)

vii. **Arson**--Any willful or malicious burning or attempt to burn, with or without intent to defraud, a dwelling house, public building, motor vehicle or aircraft, personal property of another, etc.

viii. **Arrests for Weapon Law Violations**--The violation of laws or ordinances dealing with weapon offenses, regulatory in nature, such as: manufacture, sale, or possession of deadly weapons; carrying deadly weapons, concealed or openly; furnishing deadly weapons to minors; aliens possessing deadly weapons; and all attempts to commit any of the aforementioned.

ix. **Arrests for Drug Abuse Violations**--Violations of State and local laws relating to the unlawful possession, sale, use, growing, manufacturing, and making of narcotic drugs. The relevant substances include: opium or cocaine and their derivatives (morphine, heroin, codeine); marijuana; synthetic narcotics (Demerol, methadones); and dangerous nonnarcotic drugs (barbiturates, Benzedrine).

x. **Arrests for Liquor Law Violations**--The violation of laws or ordinances prohibiting: the manufacture, sale, transporting, furnishing, possessing of intoxicating liquor; maintaining unlawful drinking places; bootlegging; operating a still; furnishing liquor to a minor or intemperate person; using a vehicle for illegal transportation of liquor; drinking on a train or public conveyance; and all attempts to commit any of the aforementioned. (Drunkenness & driving under the influence are not included in this definition.)

xi. **Disciplinary Referrals for Weapon Law Violations**

xii. **Disciplinary Referrals for Drug Abuse Violations**
Policies and Procedures

SECTION: Administration


CHAPTER: General

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POLICY: Mandatory Reporters

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xiii. Disciplinary Referrals for Liquor Law Violations
xiv. Hate Crimes
 xv. Sex Offenses
xvi. Forcible--Any sexual act directed against another person, forcibly and/or against that person’s will; or not forcibly or against the person’s will where the victim is incapable of giving consent.

xvii. Sex Offenses-Nonforcible--Unlawful, nonforcible sexual intercourse.

1. Incest. Nonforcible sexual intercourse between persons who are related to each other within the degrees wherein marriage is prohibited by law.
2. Statutory Rape. Nonforcible sexual intercourse with a person who is under the statutory age of consent.

b. Mandatory reporters are expected to report crimes covered by the Clery Act to the Department of Public Safety without delay by calling (402) 280-2911 for emergencies or (402) 280-2104 for nonemergency situations. A mandatory reporter may choose, but is not required, to provide personally identifiable information (the name of the victim, the name of the accused individual, and other identifying details about witnesses, specific location, etc.) unless a clear threat to health or safety is present, as determined by Public Safety.

c. Vice Presidents, Deans, Directors and Department Heads are expected to respond to the annual request from Public Safety to report knowledge of any crimes that may not have been previously reported to Public Safety.

3. When a mandatory reporter becomes aware of any concerning and disruptive student behaviors, the mandatory reporter must promptly contact the Office of the Vice President for Student Life.

4. Corrective action may be taken against any faculty or exempt staff member for failing to comply with the directives of this policy.

AMENDMENTS AND TERMINATION OF THIS POLICY

The University reserves the right to modify, amend or terminate this policy at any time.
Creighton University has an obligation to its students, staff, and visitors to conduct its operations and maintain its facilities in a manner consistent with its Catholic, Jesuit mission. The University recognizes that some University-sponsored programs and programs that involve children (Minors under the age of 19) and vulnerable adults (adults with a substantial functional or mental impairment). This policy provides for the appropriate supervision of children and vulnerable adults who are involved in University-sponsored programs and programs held at the University, including the housing of children and vulnerable adults in University residence halls. This policy does not apply to general public events where parents/guardians are invited and expected to provide supervision of their child or vulnerable adult. Any member of the faculty or staff who suspects that a child or vulnerable adult who is on University premises for any reason, or is participating in a University-sponsored activity at another location, has been the victim of abuse shall immediately report the suspected abuse in accordance with Nebraska state law.

POLICY

In order to ensure that the appropriate supervision of children and vulnerable adults who are involved in University-sponsored programs and programs held at the University, including the housing of children and vulnerable adults in University residence halls, it is necessary to establish certain requirements governing the presence of children and vulnerable adults on the University's campus.

These requirements are as follows:

A. All children and vulnerable adults not registered for classes who are otherwise participating in a University-sponsored program or a program taking place on University property must be supervised by an authorized adult(s) at all times while they are participating in that program.

B. All supervised children and vulnerable adults participating in a University-sponsored program or a program taking place on University property are permitted in the general use facilities (Athletic Facilities, Public Spaces, Academic Buildings, Food Services Area etc.) but may be restricted from certain areas of the facilities or from utilizing certain equipment.

C. Children and vulnerable adults are permitted at events and venues open to the public. However, the University reserves the right to determine, in its sole discretion, whether selected events or venues are appropriate for children.
SCOPE/ELIGIBILITY

This policy applies to activities and programs taking place on Creighton’s campus, or under the authority and direction of the University at other locations, in which children and vulnerable adults will be physically present and participating, with the following exceptions: (1) undergraduate and graduate academic programs; (2) research programs subject to the review and approval of Creighton’s Institutional Review Board (IRB); (3) children enrolled at the Russell Child Development Center; (4) on campus prospective student recruitment events; and (5) Family Weekend, Lil' Jays Weekend, and such other similar, ongoing programs as may be designated from time to time by the Senior Vice President, Provost or the appropriate Vice President/Provost in advance and in writing as exempted from this policy.

Athletic camps, academic camps, laboratories and workshops intended for elementary and high school students and similar activities are included within the scope of this policy. This policy applies to such programs and activities whether they are limited to daily activities or also involve the housing of children and vulnerable adults in residence halls.

Vendors, independent contractors, and other outside parties who conduct business with the University will be expected to comply with this policy as well, as specified by the terms of any contract between the University and such third party.

DEFINITIONS

- **Child**: Any person under the age of 19, including, but not limited to, those persons who are also referred to herein as “children”.

- **Vulnerable Adult**: Any adult with a substantial functional or mental impairment.

- **Authorized Adult**: A parent, legal guardian or adult who has complied with the requirements to be present with children or vulnerable adults under this policy and who is either escorting or supervising children or vulnerable adults while on campus or while participating in any activities identified in this policy.

- **Program**: An activity/event offered by an academic or administrative unit of the University, or by non-university groups using University facilities. This includes but is not limited to workshops, academic camps, sports camps, conferences, tournaments, and other similar activities.
A. Program Registration

Departmental units shall, prior to the beginning of the University's fiscal year for ongoing programs and activities and at least sixty days prior to the first scheduled date of participation by children or vulnerable adults, submit the Working with Children and Vulnerable Adults Notification Form to the Office of Equity and Inclusion.

Any requests for clarification as to whether a particular program or activity is subject to this policy, or a request for a waiver to this policy, should also be sent to the Office of Equity and Inclusion.

B. Background Checks

A completed background check will be required of each individual prior to his or her direct participation with children or vulnerable adults in an activity covered by this policy no more than six months prior to the date of activity and at least once every four (4) years thereafter. Background checks will identify criminal convictions in the United States within the last seven years and include a search of the sex offender registry of the relevant jurisdiction for each individual.

It is the responsibility of the person in charge of the program or activity to assure that each participating adult has submitted the required background check request form and has subsequently received clearance to participate. The Department of Human Resources will maintain a roster of individuals who have been cleared to participate and the dates on which a new background check will be required.

A decision not to permit an individual to participate in a program or activity covered by this Policy based on the results of a background check will be made by Human Resources after consultation with the Senior Vice President or the Provost and Office of the General Counsel. The results of background checks conducted under this policy will be used only for the purposes of this Policy, except that Creighton University reserves the right to take appropriate action with respect to employees who may have falsified or failed to disclose information on their employment applications.
C. Training

Each individual who will be participating with children or vulnerable adults in a covered program or activity shall attend annual mandatory training on the conduct requirements of this Policy, on protecting children or vulnerable adults from abusive emotional and physical treatment, and on appropriate or required reporting of incidents of improper conduct (including, but not limited to, appropriate law enforcement authorities). Upon completion of the mandatory training and completion of The Working with Children or Vulnerable Adults Self-Disclosure Form, the individual will be an authorized adult.

The appropriate Vice President/Provost, Senior Vice President, Provost, Dean or area Director in consultation with the Office of Equity and Inclusion and the Office of the General Counsel may enhance and/or modify the required training program to meet specific needs of the particular program or activity involved, but any such enhanced or modified program must include all the elements described in this section. In addition, the Vice President/Provost, Senior Vice President, Provost, Dean or area Director shall arrange for sufficiently frequent training sessions to permit covered programs and activities to continue to function on a regularly scheduled basis.

D. Conduct Requirements

Authorized adults participating in programs and activities covered by this policy shall not:

1. Have one-on-one contact with children or vulnerable adults; in general, it is expected that activities where children or vulnerable adults are present will involve two or more adult participants.

2. Participate in a sleepover under the auspices of the program or activity, unless (1) one of the child/vulnerable adult's parents or legal guardians is present or (2) one of the child/vulnerable adult's parents or legal guardians has given consent and there is at least one other adult, and the two adults remain in each other's presence at all times.

3. Engage in abusive conduct of any kind toward, or in the presence of, a child or vulnerable adults.

4. Strike, hit, administer corporal punishment to, or touch in an inappropriate or illegal manner any child or vulnerable adults.
5. Pick up children or vulnerable adults or drop off children or vulnerable adults from their homes, other than the driver's child or children or friends of the driver's child or children other than when such child or children are present, at their homes in the adult's personal vehicle, whether before, during, or after the program or activity.

6. Engage in the use of alcohol or illegal drugs, or be under the influence of alcohol or illegal drugs during such programs or activities.

7. Make pornography in any form available to children or vulnerable adults participating in programs and activities covered by this Policy or assist them in any way in gaining access to pornography.

8. Violate any local, state or federal laws.

E. Allegation of Inappropriate Conduct

Adults participating in programs and activities covered by this policy shall:

1. Immediately report any violation of the Conduct Requirements of this policy to the person in charge of the program or activity and to the Department of Public Safety, and shall contact law enforcement and emergency responders as may be appropriate under the circumstances.

2. Assure the safety of children and vulnerable adults participating in programs and activities covered by this Policy, irrespective of any other limitation or requirement, including removal of children and vulnerable adults from dangerous or potentially dangerous situations. In such case, the Department of Public Safety must be notified immediately.

3. Discontinue any further participation in programs and activities covered by this policy when an allegation of inappropriate conduct has been made against him or her, until such allegation has been satisfactorily resolved.

PROHIBITION AGAINST RETALIATION

The University expressly prohibits any form of retaliatory action against any employee for filing a bona fide complaint under this policy or for assisting in a complaint investigation.

AMENDMENTS OR TERMINATION OF THIS POLICY

Creighton University reserves the right to modify, amend, or terminate this policy at any time.
Policies and Procedures

SECTION: Administration

CHAPTER: Human Resources

POLICY: Affirmative Action/EEO

PURPOSE

The Equal Employment Opportunity and Affirmative Action Policies of Creighton University are designed to comply with federal and state equal opportunity and affirmative action-related laws. The purpose of these policies is to insure that all qualified individuals under consideration for jobs, promotions, pay raises, training programs, and so on, receive equal consideration, regardless of race, color, national origin, gender, religion, disability, and age. Compliance with these laws also results in employment-related decisions and actions that conform to the University's credo and support its mission.

POLICY

In accordance with the applicable federal laws and regulations, the employment policies and practices of Creighton University are administered without unlawful regard to race, color, religion, national origin, sex, age, disability, marital status, or veteran status. The University will promote Equal Employment Opportunity through a positive and continuing Equal Employment Opportunity Program.

This Equal Employment Opportunity Program will have as its firm objective equal opportunity in recruitment, hiring, rates of pay, promotion, training, termination, benefit plans, and all other forms of compensation and conditions and privileges of employment for all employees and applicants for employment.

The program is designed to provide Equal Employment Opportunity in an atmosphere of nondiscrimination with respect to all persons.

The University has an Affirmative Action Program. The objective of the Affirmative Action Program is to enhance employment opportunities for persons belonging to groups that historically have suffered discrimination. These groups include women, minorities, disabled persons, disabled veterans, and Vietnam era veterans. Creighton University's Affirmative Action Program is implemented through its Affirmative Action Plan. The Plan is a written document which identifies those areas in which the University is deficient in its employment of minority groups and women. The Plan sets goals and timetables for the correction of identified deficiencies.

The Plan contains action-oriented procedures to which the University will devote every good faith effort to achieve prompt and full employment of minorities and women in all segments of the University's work force where identified deficiencies exist. The Plan also promotes the full utilization of disabled persons, disabled veterans, and Vietnam era veterans.
The ultimate responsibility for Equal Employment Opportunity and Affirmative Action at the University lies with the President of the University. All Vice Presidents are responsible for Equal Employment Opportunity compliance and Affirmative Action within their divisions. Oversight responsibility for the implementation and administration of the Equal Employment Opportunity and Affirmative Action Policy is the responsibility of the Affirmative Action Director.

Successful meeting of goals and objectives will be attained through the full cooperation, support, and good-faith efforts of all Vice Presidents, Deans, Directors, Department Chairs, Supervisors, and all other personnel responsible for hiring and promotions.

This policy does not mandate the use of quotas. The University subscribes to hiring the most qualified person in all cases. However, if individuals are similarly qualified, protected class status as defined in the Affirmative Action Plan will be a plus factor in the selection decision where protected class members are underrepresented.

**SCOPE**

This policy applies to all full-time and part-time employees of Creighton University, applicants for employment, and employees of contractors to the University.

**DEFINITIONS**

*Equal Employment Opportunity* is defined as the administration of all terms and conditions of employment without regard to age, color, disability, national origin, race, religion, or sex.

*Affirmative Action Program* is the generic name referring to the entire institutional affirmative action effort, of which the written Affirmative Action Plan is one part.

*Affirmative Action Plan* is Creighton University's written plan conforming to Executive Order 11246 (federal mandate) in which the University analyzes specific problems, and identifies areas in which members of protected groups are underutilized.
In those areas, the University must set specific goals and timetables to eliminate underutilization. The Affirmative Action Plan is compiled annually by the University's Affirmative Action Director.

**PROCEDURES**

The implementation of equal employment opportunity takes place on a day-by-day basis as supervisors and others in positions of authority at Creighton University make employment-related decisions. These decisions include, but are not limited to: how, where, and for how long recruitment will take place; which applicant to hire; how much employees should be paid and what pay increases they might receive; who will be promoted; who will be eligible for advanced training opportunities and development; who will receive benefits and the form those benefits will take; and who will be terminated.

All of the employment-related decisions described in the paragraph above and other similar decisions must be made on the basis of who is best qualified or who best merits the action under contemplation. In practical terms, what this means is that employment-related decisions should always be made on the basis of predicted or actual job performance, and not based upon personal non-job related qualities or characteristics of the individual, such as his or her sex, the color of his or her skin, age, disabilities, and so on.

**ADMINISTRATION**

Equal Employment Opportunity is the responsibility of every University employee involved in employment-related decision processes, regardless of job, position, or rank.

Coordination of the University's civil rights effort and updating and dissemination of the University's Affirmative Action Plan is the responsibility of the Affirmative Action Director. Staff members are encouraged to direct inquiries or complaints regarding civil rights policy to the Affirmative Action Director.

**AMENDMENTS OR TERMINATION OF THIS POLICY**

Creighton University reserves the right to modify, amend, or terminate this policy at any time, especially in order to comply with changes in federal and state law.
PURPOSE

The Equal Employment Opportunity and Affirmative Action Policies of Creighton University are designed to comply with federal and state equal opportunity and affirmative action-related laws. The purpose of these policies is to insure that all qualified individuals under consideration for jobs, promotions, pay raises, training programs, and so on, receive equal consideration, regardless of race, color, national origin, gender, religion, disability, and age. Compliance with these laws also results in employment-related decisions and actions that conform to the University's credo and further its mission.

POLICY

Creighton University, in accordance with Section 503 of the Rehabilitation Act of 1973, as reiterated in the Americans with Disabilities Act of 1990, is committed to maintaining an Affirmative Action Program to employ and advance in employment qualified individuals with disabilities at all levels of employment, including the executive level. Such action shall apply to all employment practices including, but not limited to, hiring, upgrading, demotion or transfer, recruitment or recruitment advertising, layoff or termination, rates of pay or other forms of compensation, and selection for training.

Disabled individuals who wish to participate in the Section 503 Affirmative Action Program shall be invited to voluntarily identify themselves. The invitation to identify will make it clear that identification is voluntary and that all disclosed information shall be kept confidential.

Employment records will be reviewed to identify qualified individuals with a disability who are available for promotion and an effort will be made to fully utilize present and potential skills of individuals with disabilities. The University shall make reasonable accommodations to individuals with disabilities unless such accommodation imposes undue hardship on the University.

Whatever information the University receives concerning an individual's disabilities will be kept confidential except that a) supervisors and advisors may be informed regarding restrictions on the work or duties of individuals with disabilities and may also be informed regarding accommodations; b) first aid and safety personnel may be informed to the extent appropriate, if the physical or mental impairment might require unique or emergency treatment; and c) government officials investigating compliance with the act shall be informed.
SCOPE

This policy applies to all full-time and part-time employees of Creighton University, applicants for employment, and employees of contractors to the University.

DEFINITIONS

For purposes of this policy, "Individual with a Disability" means any person who 1) has a physical or mental impairment which substantially limits one or more of such person's major life activities, 2) has a record of such impairment, or 3) is regarded as having such an impairment.

For purposes of this policy, an individual with a disability is "substantially limited" if he or she is likely to experience difficulty in securing, retaining, or advancing in employment because of a disability.

PROCEDURES

The implementation of equal employment opportunity takes place on a day-by-day basis as supervisors and others in positions of authority at Creighton University make employment-related decisions. These decisions include, but are not limited to: how, where, and for how long recruitment will take place; which applicant to hire; how much employees should be paid and what pay increases they might receive; who will be promoted; who will be eligible for advanced training opportunities and development; who will receive benefits and the form those benefits will take; and who will be terminated.

All of the employment-related decisions described in the paragraph above and other similar decisions must be made on the basis of who is best qualified or who best merits the action under contemplation. In practical terms, what this means is that employment-related decisions should always be made on the basis of predicted or actual job performance, and not based upon personal non-job related qualities or characteristics of the individual, such as his or her gender, the color of his or her skin, age, disabilities, and so on.
ADMINISTRATION

Equal Employment Opportunity is the responsibility of every University employee involved in employment-related decision processes, regardless of job, position, or rank.

Coordination of the University's civil rights effort and updating and transmission of the University's Affirmative Action Plan is the responsibility of the Affirmative Action Director. Staff members are encouraged to direct inquiries or complaints regarding civil rights policy to the Affirmative Action Director.

Questions about hiring, promotion, evaluation, compensation, and other human resource related issues that have implications for equal employment can also be directed to the University's Human Resources Department and the Director of Human Resources.

AMENDMENTS OR TERMINATION OF THIS POLICY

Creighton University reserves the right to modify, amend, or terminate this policy at any time, especially to comply with changes in federal and state law.
PURPOSE

To ensure employees refrain from engaging in any activities that place them in conflict of interest between their official activities and any other interest or obligation. The University attempts to avoid favoritism, the appearance of favoritism and conflicts of interest in employment decisions.

SCOPE

This policy applies to all full-time, part-time and temporary faculty, employees and student employees. In addition, this policy applies to non-employees who provide services on a contractual or volunteer basis.

DEFINITIONS

Relative: Spouse, parent, grandparent, daughter, son, sister, brother, niece, nephew and all the preceding relatives who are in-laws, foster or step-relatives. In addition, a non-relative living in the same household as the employee is subject to the provisions of this policy.

Supervision: The authority to recommend or approve hiring, termination, appointment, transfer, promotion, salary adjustment, termination or prepare and approve employee performance evaluations.

POLICY

No person shall be hired, appointed, transferred or promoted to, accepted as a volunteer, or otherwise employed in any position if, as a result, in the position, he/she would provide immediate supervision to or receive immediate supervision from a relative.

PROCEDURES

1. Caution will be exercised in personnel management decisions to ensure an employee is not placed into a reporting relationship with a relative as defined by this policy.

2. A supervisor who becomes related to an employee in the direct line of authority of the supervisor shall notify the department head within 10 working days after the supervisor and employee become related.
3. Upon receiving notification from a supervisor of a relationship, the department head will contact the Director of Human Resources. The Director of Human Resources will consult with the department head and the applicable area Vice President to determine the appropriate action to be taken.

4. Exceptions to this policy must have the prior written approval of the University President in coordination with the applicable area Vice President.

ADMINISTRATION AND INTERPRETATION: Questions regarding this policy should be directed to the Director of Human Resources.

AMENDMENTS OR TERMINATION OF THIS POLICY: Creighton University reserves the right to modify, amend, or terminate this policy at any time.
Policies and Procedures

SECTION: Administration

CHAPTER: Human Resources

POLICY: Relationships Between Employees and Students

PURPOSE

This policy explicitly states the University's position on personal relationships between students and employees of the University. Communication of this policy to all employees can clarify expectations about proper employee conduct and aid in preventing allegations of sexual harassment.

POLICY

By selecting and utilizing the educational programs of Creighton University, students and their parents have demonstrated confidence in the University. In their personal dealings with students, University employees are representatives of the University and are expected to exemplify its Christian and educational values. It is incumbent upon all those who are in positions of authority over students not to abuse, or seem to abuse, the power with which they are entrusted.

Personal relationships between employees and students may have the effect of undermining the atmosphere of trust and mutual respect upon which the educational process depends. Particularly troublesome are romantic relationships. Even when both parties have consented to such a relationship, it is the employee who holds a position of special responsibility within the University. It is the employee, therefore, who will be held accountable for unprofessional behavior.

Employees should be aware that a romantic relationship with a student may render them liable for disciplinary action if the relationship creates, reasonably has the potential to create, or reasonably appears to create a conflict between the employee's personal interests and the employee's obligations to the University or its students.

Because graduate student teaching fellows, tutors, and undergraduate teaching assistants may be less accustomed than other employees to thinking of themselves as possessing professional responsibilities, they should be particularly sensitive and exercise special care in their relationships with students whom they instruct or evaluate.

SCOPE

This policy applies to all University employees.
**Policies and Procedures**

**SECTION:** Administration  
**NO.:** 2.2.5.  
**CHAPTER:** Human Resources  
**ISSUED:** 9/27/85  
**POLICY:** Relationships Between Employees and Students  
**PAGE 2 OF 2**

**PROCEDURES**

It is the responsibility of individual supervisors to communicate this policy to their employees. In addition, supervisors may need to counsel individual employees whose behavior points to a lack of awareness of this policy. If an employee persists in behaving inappropriately toward a student or students, appropriate disciplinary action, as outlined in the University's progressive discipline policy, may be administered by the supervisor.

It is important that supervisors realize they may be held legally responsible for the behavior of employees under their supervision, should a sexual harassment or other legal proceeding ensue from an employee's behavior.

**ADMINISTRATION AND INTERPRETATIONS**

For guidance in interpreting and administering this policy, supervisors may contact the Human Resources Department of the University, the University's Director of Human Resources, or the University's Affirmative Action Director.

**AMENDMENTS OR TERMINATION OF THIS POLICY**

Creighton University reserves the right to modify, amend, or terminate this policy at any time.
Policies and Procedures

SECTION: Administration
NO. 2.2.7.

CHAPTER: Human Resources
ISSUED: 3/3/77
REV. A
REV. B

POLICY: Personnel Files - Access

PURPOSE

This policy was written to insure that University employees' rights to privacy, related to information contained in personnel records, are preserved. At the same time, this policy acknowledges that under certain circumstances, supervisors and others with legitimate reasons may have access to information contained in personnel files. The policy also protects contributors to personnel files who were promised that information provided by them would remain confidential.

POLICY

Access to personnel files follows from principles of fair information practice designed to protect an individual's right to privacy and right to know, while meeting the legitimate needs of the University, government, and society. The University therefore limits access to personnel files. Also, it assures an employee the "right to know" by providing the employee with access to his or her own file to review and inspect the records except material that was solicited, submitted, and received under an explicit or implicit grant of confidentiality.

SCOPE

Access to personnel records, including faculty files, is the same for all who are employed by the University.

DEFINITIONS

For purposes of this policy, personnel files or personnel records are defined as those files or records containing employment-related information about University employees in any of several sites, including the Human Resources Department, and individual academic or administrative departments and offices.

PROCEDURES

A. The individual employee has access to his or her file, is to know what use is made of its contents, and has the right to challenge inaccuracies. Permission to view the contents of the file should be granted by the relevant supervisor or administrator. The supervisor or administrator should not, however, give the file to the employee but go through it with him or her.

B. Only information germane to the position, or job of the subject, should be kept in an employee's file.
C. Performance evaluations should be kept in the individual faculty or staff files and may be challenged by the employee. If the supervisor has used adverse confidential information from others in arriving at the evaluation, he or she should give the subject a chance to reply without revealing the source. If the supervisor considers the reply convincing, the original confidant will be informed and the adverse information destroyed. If the reply is not adequate, the adverse information will be kept in the subject's file with the source unidentified.

D. On legitimate request, Human Resources or any appropriate office is authorized to release directory information (name, address, phone, dates of employment, and occupation.)

E. Supervisors in line above have access to files of those reporting to them directly or indirectly. For example, the President could see all personnel files; the Vice President of Health Sciences could see files of his or her deans, department heads, faculty, and others in Health Sciences; department heads could see files of faculty and staff in their units, and so on. By subpoena, law enforcement agencies could have access. Other access requires consent of the subject of the file.

F. Personal information in University data banks (personally identifiable information), as distinguished from the information in the individual files in the office of the Academic Vice President and in Human Resources, is to be strictly confidential. This is management information to be used for research, payroll, mailings, and the like. Only appropriate administrators and staff who must work with this data should have access.

ADMINISTRATION AND INTERPRETATIONS

Every supervisor is responsible for managing access to personnel records housed in his or her work area. Supervisors should follow the procedures listed above when employees ask for access to their own, or others', personnel files. In addition, supervisors must ensure that employees in their work unit understand and abide by the procedures listed above.

Questions related to the management of access to personnel records should be directed to the Human Resources Department, or the Director of Human Resources. The University's General Counsel can also be of assistance in interpreting this policy.

AMENDMENTS OR TERMINATION OF THIS POLICY

Creighton University reserves the right to modify or amend this policy at any time.
Policies and Procedures

SECTION: Administration

CHAPTER: Human Resources

POLICY:
Extra Salary Payments for Exempt Employees

PURPOSE
The University's policy toward extra salary payments for exempt employees is designed to help regularize, predict, and control the outflow of budgetary funds designated for wage and salary purposes.

POLICY
University salary administration precludes the payment of overtime to exempt employees. However, in exceptional circumstances, regular full-time exempt non-faculty employees may earn salary compensation in addition to regular pay. As an exception to the usual practice, additional pay for extraordinary work may be granted subject to the following conditions:

1. Prior approval of the interested Vice President(s)
2. Final approval of the President

SCOPE
This policy applies to all University employees classified as exempt.

DEFINITIONS

Exempt employees are those who are not required to be paid overtime under the Fair Labor Standards Act because their positions are classified as executive, administrative, professional, or outside sales. In determining whether an individual holds an exempt position, three major factors are considered:

- Job requirements for independent action (called discretionary authority)
- Percentage of time spent performing routine, manual, or clerical work
- Earnings level

PROCEDURES
It is important that exempt employees not be misled or misinformed regarding compensation for "extra" work (consulting, for example, with the University as client.) Whenever supervisors are involved in discussions related to extra work, it is their responsibility to inform the employee that University policy precludes special payment.
In the event that exceptional circumstance arise, requests for special compensation must be approved by the relevant Vice President and the President as stated in the policy itself.

**ADMINISTRATION**

Questions regarding this policy and questions about employee compensation, in general, can be referred to the University's Human Resources Department and to the University's Director of Human Resources.

**AMENDMENTS OR TERMINATION OF THIS POLICY**

Creighton University reserves the right to modify, amend, or terminate this policy at any time, especially in order to comply with changes in federal wage laws.
PURPOSE

The purpose of this policy is to outline procedures to be used in the event of the University closing or curtailing operations due to severe weather or other emergency situations.

POLICY

The decision to close or delay opening of the University due to severe weather or other emergency situations rests with the President. Independent decisions may not be made at the college, school, or department level.

1. **Closing/Delayed Opening.** During severe weather (e.g., winter storms), the decision to close or delay opening the University will be made as early as possible, but not later than 6:00 a.m. The Public Relations Department will relay applicable information to the local news media. Creighton employees are advised to listen to newscasts on mornings when severe weather conditions may force the closing or delayed opening of the University. Creighton’s clinical employees will check the University Weather Hotline, (402) 280-5800, to determine if the clinics are closing or delaying their opening.

2. **Curtailing Operations.** If severe weather or an emergency situation develops during the work day and creates conditions that warrant early closing of the University, Public Safety or the President’s Office will notify the Vice Presidents of the decision, who will then notify employees within their respective areas of responsibility. Creighton’s clinical employees will be notified by the respective supervisors if the clinics are going to close early with the rest of the University.

3. **Weather Hot Line.** Employees can access the Creighton University Weather Hot Line (280-5800) to determine the status of University operations. The recording will indicate whether the University is operating under normal conditions, closed, a delayed start or curtailment of operations.

4. **Employee Responsibilities.** In the event of severe weather or other emergency situations when the University remains open, all employees are expected to make every reasonable effort to maintain their regular work schedules, but are advised to avoid undue risks in traveling. Except for emergency personnel (see paragraph 6), employees who may be concerned about safety in traveling to and from work may use their own judgment whether to stay home or leave work early after consulting with their supervisors. However, they will be expected to charge the time off to vacation, accumulated holiday hours or leave without pay. Sick time may not be used for this purpose.

5. **Excused Time.** If the decision is made to close, delay opening or curtail operations, employees will charge the time off (hours not worked) to “excused time.” They will not be required to make up the lost time. However, if the employee would have otherwise been absent due to a regularly scheduled day off or the use of sick and/or vacation time, excused time will not be used.
6. **Emergency Personnel.** Some departments have employees who are required to report or remain at work regardless of severe weather or other emergency situations (e.g., Public Safety, Facilities Management, Health Sciences, etc.) Department heads will identify those employees whose presence during periods of closure is absolutely necessary. Employees who are required to work during a weather or other emergency-related closing, will be managed as follows:

<table>
<thead>
<tr>
<th>If the Employee is:</th>
<th>Option 1</th>
<th>Option 2</th>
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<tbody>
<tr>
<td>Paid on a monthly basis</td>
<td>X</td>
<td></td>
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<tr>
<td>Paid on an hourly (bi-weekly basis)</td>
<td>X</td>
<td>X</td>
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**Option 1:** If workloads permit, the employee may receive equivalent time off with pay equal to the number of hours actually worked up to the amount of hours the University was actually closed. The equivalent time off must be taken no later than the end of the last pay period of the current fiscal year.

**Option 2:** The employee may be paid for the hours actually worked during the period the University was closed AND record excused time on his/her timesheet for an identical number of hours within the same pay period. However, only the actual hours worked will be included when calculating overtime pay.

**Note:** Managers shall determine which option will be used.

7. **Creighton Medical Clinics.** During periods when the University is closed due to inclement weather, Creighton Medical Clinics maintain adequate staffing to provide patient care services. Therefore, information specific to the status of the Creighton Medical Clinics will be provided via the University’s official weather hotline, (402) 280-5800. The procedures outlined in paragraph 6 above also apply to Creighton Medical Clinic employees.

**SCOPE**

This policy applies to all benefit eligible University employees.

**ADMINISTRATION AND INTERPRETATIONS**

Questions regarding this policy should be directed to the University’s Human Resources Department.

**AMENDMENTS OR TERMINATION OF THIS POLICY**

Creighton University reserves the right to modify, amend, or terminate this policy at any time.
PURPOSE

It is the policy of Creighton University to provide fair and uniform treatment for employees whose jobs are eliminated. This document outlines the steps to be followed in making a reduction in force (RIF) decision and a plan. It also provides employment assistance information for employees affected by a RIF.

When the business needs of a department dictate organizational review and change, the Director of Human Resources or designee must be consulted early in the planning process. The Director of Human Resources or designee shall inform the affected department of all applicable expenses that will be related to this action. The affected department will be responsible for paying such costs. All necessary actions shall be taken to ensure that decisions are made based upon careful analysis and that employees are treated fairly and offered opportunities for assistance and re-employment when possible.

SCOPE

This policy applies to all benefit-eligible employees; but, specifically excluded from eligibility under this policy are:
- Employees who are in their first 90 days of employment
- Changes in work schedule or hours
- Temporary and student employees
- Housestaff/Resident employees
- Grant-funded positions and employees who occupy positions funded (full or partial) by extramural dollars (e.g. grants, drug studies, etc.) who are hired with the understanding that all or part of the position could end when the particular funds are exhausted.
- Faculty (not eligible for the provisions of this policy as they are governed by other contractual provisions contained in the Faculty Handbook and policy 4.2.4 - Termination Rights of Non-Tenure-Track Faculty in Grant-Funded Positions).

POLICY

Any employee affected by a RIF will receive verbal and written notification from his/her supervisor or department head a minimum of 30 calendar days prior to the elimination of his/her position. The department has the option to offer pay in lieu of notice or have the employee work the 30 days.

At the time of written notification and prior to severance payment, the employee will be presented an Acceptance of Severance Agreement and Release. The obligations under the agreement shall be explained at the time it is presented and include explanation of timeframes. If the employee chooses not to sign the Acceptance of Severance Agreement and Release, he/she forgoes any severance pay and benefits (except those required to be paid under federal law) stated in the policy, but the RIF action will occur nonetheless.
Policies and Procedures

SECTION: Administration

CHAPTER: Human Resources

POLICY: Reduction in Force

Severance pay is calculated based on benefit-eligible service as follows:

- **Employed in a benefit-eligible status for 24 months or less:** Severance pay is equal to two week’s pay based on the employee’s base pay rate (excluding differential rate, on-call, bonus, etc.) as of the date of separation.

- **Employed in a benefit-eligible status for more than 24 months:** Severance pay is equal to one week’s pay for each full year of service to the University up to a maximum of 12 weeks of severance. The amount of severance pay will be based on the employee’s base pay rate (excluding differential rate, on-call, bonus, etc.) as of the date of separation.

- Any unused holiday hours earned prior to the date of separation will be paid.

- Tuition remission benefits currently being used by the employee, spouse or eligible dependent child (ren) will continue until the end of the current academic semester in which the date of separation occurs.

- No additional vacation, sick leave, holidays or retirement plan contribution(s) (to include the University’s matching contribution), will accrue beyond the date of separation and will not be included in the calculation of severance pay.

- Participation in health and/or dental insurance coverage(s) will end on the last day of the month in which the date of separation occurs.
  - An employee participating in health and/or dental insurance on the date of separation will be offered the opportunity to continue coverage under Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).
  - If the employee exercises this option, the University will continue to cost share the premiums for the first three months. At the end of the initial three-month period, the employee may continue medical and/or dental coverage for an additional 15 months, if he/she pays the total monthly premium. Employee’s other benefits will end according to the terms of the University provided benefit plans.

An employee who is affected by a RIF action may utilize outplacement services coordinated and determined through Human Resources and as outlined in the Severance Agreement. The applicable department is responsible for the costs associated with outplacement services.
An employee whose position is scheduled for elimination and begins benefit-eligible employment in another position within the University within the 30 calendar day notification period shall not be eligible for the benefits of this policy. An employee who is affected by a RIF action is required to follow the normal application procedures to apply for open positions at Creighton University.

**PROCEDURE**

When a RIF is being considered, the department manager(s) shall contact the Director of Human Resources or designee for a discussion of the proposed action. Should a RIF be necessary the department will work with the Human Resources department to articulate the justification for the RIF action and the criteria for determining which employee(s) will be affected by the RIF action. A RIF may be implemented:

(i) when a position is eliminated;
(ii) when a department reorganizes or discontinues some of its functions; or
(iii) when a position’s essential functions and/or core responsibilities change significantly and permanently, as determined by the Director of Human Resources or designee.

The following criteria will be utilized when determining the specific employee(s) to be affected by the proposed RIF action. These criteria need not be considered in the order listed, but all of these factors should be taken into account:

- Knowledge, skills, education/training and abilities to perform the essential functions of the job
- Performance: Based on performance evaluation ratings and disciplinary action/performance improvement plans
- Years of service

Department Manager &/or Human Resources shall forward the completed justification packet to the applicable Vice President for review and action. The packet is returned to Human Resources. If a RIF affects 3 or more people, Human Resources, in conjunction with the Vice President, shall present the packet to the President to make the final decision.

An employee affected by the RIF will receive a private, confidential, verbal and written notification from the immediate supervisor or department head and a Human Resources representative a minimum of 30 calendar days prior to the elimination of the position. The written notification is not to be sent or delivered to the employee without a prior verbal conversation to include the employee, the supervisor and a Human Resources representative. The written notice will include, but is not limited to:

a. The reason for the action
b. The date of the separation
c. A copy of this policy
d. Reference letter indicating employee displaced due to RIF
Following verbal and written notification the Human Resources department will continue to work with the employee to resolve issues and answer questions surrounding the RIF action. The option of seeking other employment within the University shall also be presented to the employee.

AMENDMENTS OR TERMINATION OF THIS POLICY

This policy does not constitute a contract between Creighton University and its employees. The University may modify, amend, or revoke this policy at any time for any reason. Any modifications, amendments, or revocation shall be prospective in nature only and shall not affect employees already notified of the reduction in force.

The University may vary its actions from the procedures specified herein if the actions would place the University in non-compliance with federal, state or local laws.

ADMINISTRATION, INTERPRETATIONS, AND EXCEPTIONS

Human Resources will coordinate and monitor all reduction in force activities under this policy. The Senior Vice President for Operations, who has direct supervisory authority over the Human Resources Department, shall have ultimate responsibility for implementation of the Reduction in Force Policy.
INSTITUTIONS INVOLVED

Creighton University
Area High Schools:
  Brownell-Talbot High School
  Creighton Preparatory School ($1,000 discount)
  Daniel J. Gross High School
  Duchesne Academy ($1,000 discount)
  Mercy High School (20% reduction)
  Mount Michael High School
  Roncalli High School
  Saint Albert Catholic Schools
  Skutt High School

ELIGIBLE STUDENTS

Creighton University
  Dependent children of full-time faculty and staff with three years of service* to the University may apply for up to 25% reduction at the above named schools.

High Schools
  High school faculty and designated administrators, and their dependent children, and spouses.

AMOUNT OF TUITION REDUCTION

By Creighton University
  Eligible high school faculty, designated administrators and the spouses and dependent children of eligible high school faculty and designated administrators will receive tuition reduction of up to 25% of base tuition in undergraduate programs in the College of Arts and Sciences, the College of Business Administration, the School of Nursing, and University College.

By High Schools
  Dependent children of eligible University employees will receive a tuition reduction of up to 25% of the base tuition from the high schools.
NOTIFICATION OF ELIGIBLE STUDENTS

By Creighton University

Each year by May 1st the Plan Coordinator will notify the various high school principals with the names of persons eligible for up to 25% tuition reduction from the high school.

By High School

Prior to the start of each semester the high school principals will notify the Plan Coordinator of the names eligible for up to 25% tuition reduction from the University.

REPORTING AND EVALUATION

Each year by May 1st the Plan Coordinator will render a total activity report to all schools involved. From time to time the schools may want to have a meeting to evaluate the whole program and suggest possible adjustments for consideration.

PLAN COORDINATOR

The Plan Coordinator will be appointed by the University Vice President for Finance. Interested University personnel may contact the University Business Office for assistance or information regarding this policy. Contact the University Business Office for an application form.

CONTINUATION OF POLICY

The University reserves the right to terminate or modify this policy at any time. The high schools may terminate participation in this program at any time. This policy shall not vest in any person any contractual or legal right to demand any tuition reduction (or compensation in lieu of tuition reduction) from any person or entity described or mentioned herein.

ALTERNATE REMISSION BENEFIT

In cases where the amount of awards are not equitable for a given year, the University will work with the individual high schools to increase the award levels in an attempt to equalize the benefits received by each institution. All alternate remission dollars must be used by June 30 of the following year or be forfeited.

* To be eligible for the High School Reciprocal Reduction Program, a faculty or staff member must complete three years continuous benefit eligible service prior to September 1st of the high school academic year for which the benefit is sought.
Policies and Procedures

SECTION:
Administration

NO.
2.2.12.

CHAPTER:
Human Resources

ISSUED: 1967
REV. A 9/11/96
REV. B 12/5/98
REV. C 12/12/02
REV. D 9/1/04
REV. E 4/8/11

POLICY:
Tuition Remission

PAGE 1 OF 4

I. PURPOSE:

The purpose of this policy is to outline policies and procedures for utilizing Creighton University’s tuition remission benefit.

II. SCOPE:

Specific eligibility for and administration of tuition remission benefits are shown in the table on page 2 of this policy. Please note: All service (employment) requirements for eligibility are “benefit-eligible” service.

III. POLICY:

A. Students must first be accepted through the established procedures within their chosen college or school. Acceptance as a student does not guarantee remission of tuition nor does eligibility for tuition remission guarantee admission as a student. In addition, participation in the tuition remission program does not ensure the award of a degree.

B. Employees who are rehired on or after October 1, 2004, must reestablish eligibility by meeting the service requirements as outlined in the table on page 2 of this policy.

C. Participation in the tuition remission program may begin with the first semester or summer session following completion of the service requirement.

D. An employee may attend courses during work hours with the approval of his or her immediate supervisor. Lost work time resulting from class attendance must be made up.

E. A “retiree” is defined as an employee who has reached age 60 with a minimum of ten years’ benefit-eligible service.

F. An administrative fee is assessed each semester or summer session for each participant in the tuition remission program. Registration and other fees for participants in the tuition remission program are the same as for other students and are in addition to the tuition remission administrative fee. As fees periodically change, visit the Business Office website for the most current information. Any financial charges that the employee or their spouse/dependent child has incurred from previous terms must be paid in accordance with established Business Office procedures prior to any usage of tuition remission for the upcoming term. Tuition remission will not be granted retroactively.
G. The tuition remission program is administered according to the following table:

<table>
<thead>
<tr>
<th>Current Employment Status:</th>
<th>Remission Benefit:</th>
<th>Waiting Period:</th>
<th>Credit Hour Limit:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full-time (note 5) Employee with continuous benefit eligible service beginning before 10/1/2004</td>
<td>100% remission for self/spouse/dependent child</td>
<td>None</td>
<td>No credit limit for self (note 1) 136 undergraduate credit hours for spouse and/or dependent child (note 4)</td>
</tr>
<tr>
<td></td>
<td>100% remission for self</td>
<td>6 months consecutive full-time (note 5) employment</td>
<td>No credit limit (note 1)</td>
</tr>
<tr>
<td></td>
<td>50% remission for spouse/dependent child</td>
<td>3 years consecutive full-time (note 5) employment</td>
<td>136 undergraduate credit hours (note 4)</td>
</tr>
<tr>
<td></td>
<td>75% remission for spouse/dependent child</td>
<td>4 years consecutive full-time (note 5) employment</td>
<td></td>
</tr>
<tr>
<td></td>
<td>100% remission for spouse/dependent child</td>
<td>5 years consecutive full-time (note 5) employment</td>
<td></td>
</tr>
<tr>
<td>Adjunct faculty and part-time staff (note 6)</td>
<td>33-1/3% remission for self/spouse/dependent child</td>
<td>5 years consecutive employment</td>
<td>No credit limit for self (note 1) 136 undergraduate credit hours for spouse and/or dependent child (note 4)</td>
</tr>
<tr>
<td>Retiree</td>
<td>Self/spouse/dependent child (note 2)</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Disabled Employee with 10 years of benefit eligible service (note 3)</td>
<td>Self/spouse/dependent child (note 2)</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Deceased Employee with 10 years of benefit eligible service (note 3)</td>
<td>Spouse/dependent child (note 2)</td>
<td>None</td>
<td>136 undergraduate credit hours for spouse and/or dependent child (note 4)</td>
</tr>
</tbody>
</table>

Note 1: Participation is limited to the monetary value of two courses per semester or combined Summer Sessions.
Note 2: Amount of remission benefit is determined when the benefit is received, based on the current policy then in force.
Note 3: The disabling condition or death must have occurred while the individual was actively employed by the University.
Note 4: Tuition expenses beyond 136 undergraduate credit hours will be at the student’s own expense. This 136 undergraduate credit hour limit includes all courses completed or attempted where the University’s tuition remission budget has paid for the course(s) (e.g., withdrawals past the official “drop/add” date and course(s) re-taken due to failure, incomplete, etc.) as well as courses completed or attempted as part of the FACHEX and Tuition Exchange programs. (Continued on next page)

**Policies and Procedures**
Note 5: For Tuition Remission purposes, full-time is defined as: For members of the faculty, full-time is defined by the terms of their faculty contract. For members of the staff, full-time is defined by their full-time equivalent (FTE) percent. The FTE percent must be equal to or greater than 75% (annual scheduled hours equal to or greater than 1,560).

Note 6: For Tuition Remission purposes, part-time is defined as: For members of the faculty, eligibility for part-time remission benefits is defined by the percentage of work load as stated in their faculty contract. For members of the staff, eligibility for part-time remission benefits is defined by their full-time equivalent (FTE) percent. The FTE percent must be equal to or greater than 50% (annual scheduled hours equaling 1,040 up to 1,559).

H. To remain eligible for tuition remission, the student must:

• remain in good academic standing as determined by his/her academic Dean
• maintain a minimum cumulative QPA of 2.3 beginning with the end of sophomore year. QPA’s will be reviewed at the end of each academic year.
• maintain satisfactory progress toward a degree, meaning: a) the student has acquired a minimum of 24 credit hours after one academic year, 48 credit hours after two academic years, and 72 credit hours after three academic years, and b) the student, by the start of the third academic year, has declared in writing a specific degree in a major program of study and successfully completes a reasonable number of courses in that program each semester thereafter.
• not be on disciplinary probation or suspension at Creighton University, as defined in the Student Discipline Policies and Procedures in the Creighton University Student Handbook.
• not be on disciplinary probation, suspension or expulsion as a result of non-academic misconduct at any other institution of higher education.

A student who fails to maintain the above requirements will become ineligible for continued participation in the tuition remission program. This ineligibility will continue for the period of time necessary to bring his/her academic and or conduct record back into compliance, and/or to satisfactorily complete the suspension or probationary period, and any requirements imposed as part of the sanctions. During that period, the student is responsible for all costs of his/her education.

I. Use of the tuition remission benefit applies only to the following schools, colleges and University programs:

<table>
<thead>
<tr>
<th>Arts and Sciences</th>
<th>Business Administration</th>
<th>University College</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing (BSN only)</td>
<td>Graduate School (see Note)</td>
<td>Summer Sessions</td>
</tr>
</tbody>
</table>

Note: Graduate School tuition remission is available for active employees only. Some programs in the Graduate School are excluded from coverage under tuition remission. See HR website – Tuition Remission for further information on these exclusions. In addition, the value of Graduate School tuition remitted may be considered taxable income to the employee in accordance with Internal Revenue Service (IRS) regulations.
Policies and Procedures

SECTION: Administration

NO. 2.2.12.

CHAPTER: Human Resources


POLICY: Tuition Remission

J. The following are not included in the tuition remission program: Independent Study Programs offered through University College; Accelerated Nursing Program; Advanced Placement courses taken by current high school students; the Doctorate of Education (Ed.D.) in Leadership; and Travel Courses.

K. Within the description of tuition remission benefits available for a dependent child, “dependent” refers to the employee’s child, step-child or adopted child, under age 24 (Note: employees with an initial employment date or re-employment date prior to October 1, 2004, may receive tuition remission for his/her dependent child under age 25) who has never been married, and who is qualified to receive a “qualified tuition reduction” under the IRS Code. The University may request evidence of such qualification.

L. Upon a dependent child’s initial participation in the tuition remission program, and annually thereafter, he or she is required to apply for federal financial aid (excluding loans) with the University’s Student Financial Aid Office. Outside grants and scholarship awards will be applied to tuition first, unless otherwise directed by the funding source. The tuition remission benefit will then be applied to the tuition balance as part of the total financial aid package.

If the student is eligible for both tuition remission and an internal financial aid award, the student will only receive the larger of the two. For example, if a student has earned a 50% merit scholarship and is eligible to receive a 75% tuition remission benefit, the student would receive the tuition remission benefit because it is the larger of the two and be responsible for the remaining 25%.

M. The University’s Registrar Office administers the Faculty and Staff Children’s Exchange (FACHEX) and Tuition Exchange Programs. A dependent child eligible for 100% tuition remission may apply for participation in these programs. An annual participation fee is assessed for each dependent child receiving a tuition exchange scholarship. This fee is collected by the Registrar’s Office.

IV. PROCEDURES:

Applying for tuition remission is a procedure separate from admission to the University. Applications for tuition remission must be received in the Human Resources Department not later than the applicable semester’s (or summer session’s) first official day of class as determined by the University Registrar. An established online submission process is available on the Human Resources website under the Benefits heading. Applications received after this date will not be processed.

V. AMENDMENTS OR TERMINATION OF THIS POLICY:

Creighton University reserves the right to modify, amend or terminate this policy at any time.
The University has Vicarious Professional Liability Insurance to cover its own legal liability for hospital and medical malpractice. The insurance also covers all students and employees of the University while acting within their duties as students and employees. Licensed employees (doctors of medicine and dentistry, registered pharmacists and registered nurses) are covered by separate policies.

The above policy statement on malpractice insurance is made upon the advice and counsel of the University's attorneys and the University's insurance advisors. This statement is not a contract of insurance coverage. Any insurance coverage is subject to the terms and provisions of the policies and contracts of insurance provided.
Policies and Procedures

SECTION:
Administration

CHAPTER:
Human Resources

POLICY:
Family and Medical Leave

PURPOSE

The Family and Medical Leave Act of 1993 (FMLA) requires employers with 50 or more employees to allow eligible employees to take up to 12 workweeks of unpaid, protected leave in a 12-month period for specified family and medical reasons. During the leave, an employee is entitled to job protection and the retention of health benefits as if active employment were continuous. Upon return from the leave, an employee must be reinstated to his/her former or an equivalent position. As a Roman Catholic institution in the Jesuit tradition, Creighton University strives to protect the dignity of all persons. The University will provide a total of 12 workweeks in a “rolling” 12-month period of job protected unpaid leave to employees as mandated by Federal and State Law.

SCOPE/ELIGIBILITY

This policy defines the terms and conditions of FMLA leave. The Act and the regulations of the Department of Labor shall be referred to for any questions not addressed by this policy. The University shall determine in each case whether an absence qualifies as an FMLA leave. The University has chosen to require the use of paid time off while taking FMLA leave.

Employees are eligible if they have worked for the University for at least twelve (12) months in the last seven (7) years and worked at least 1,250 hours for the University during the twelve (12) months preceding the commencement of the leave.

POLICY

The Family and Medical Leave Act requires covered employers to provide up to twelve (12) weeks of unpaid, job protected leave to eligible employees for the following reasons:

- For a serious health condition that makes the employee unable to perform the employee's job;
- To care for the employee's spouse, son or daughter, or parent, who has a serious health condition;
- For incapacity due to pregnancy, prenatal medical care or childbirth; or,
- To care for the employee's child after birth, or placement for adoption or foster care

Such a leave is referred to in this policy as "FMLA leave."
Policies and Procedures

SECTION:
Administration

CHAPTER:
Human Resources

POLICY:
Family and Medical Leave

Duration

An employee's cumulative total of all leaves of absence under this policy may not exceed twelve (12) weeks in any twelve- (12) month period. The twelve- (12) month period will be measured on a rolling twelve- (12) month period from the date an employee uses any FMLA leave. A husband and wife who are eligible for FMLA leave and are employed by the University are entitled to twelve (12) weeks of leave each during any twelve- (12) month period if the leave is taken for the birth of a child or to care for the child after the birth, or for placement of a child with the employee for adoption or foster care or to care for the child after placement. FMLA leave for the birth of a child, or placement of a child for foster care or adoption, must be completed within one (1) year after the birth or placement.

Intermittent/Reduced Schedule

An employee does not need to use this leave in one block. Leave may be taken on an intermittent or reduced schedule basis only when the leave is because of a serious health condition, and the intermittent leave or reduced schedule is shown to be medically necessary. Medical certification of this need will be required. Where the intermittent leave or reduced schedule is foreseeable, the employee must try to schedule the leave so as not to unduly disrupt University operations, and if the employee needs to be absent due to planned medical treatments, the employee may be temporarily transferred to an alternative position with equal pay and benefits for which the employee is qualified and which better accommodates the intermittent or reduced schedule leave.

Regular Reporting

While on FMLA leave, employees must keep the University informed of their plans to return to work. As a general rule, the employee must contact the Human Resources Department at least once every two (2) weeks; other reporting schedules may be agreed on between the employee and the Human Resources Department based on the employee's individual circumstances. Reasonable notice (at least two business days, and more if possible) is required prior to returning to work on any date other than the originally scheduled return date.

Salary/Wages

FMLA leave shall be unpaid, except as follows:

a. If the employee has earned, but has not used, paid time off for which the employee is eligible, that time off must be applied concurrently until it is exhausted.

b. If the absence is due to a job-related injury, the employee may be covered by worker's compensation. If worker's compensation benefits apply, the employee will not be required to apply any accrued time off, but may elect to do so to the extent that the worker's compensation is less than the employee's regular salary.
Benefits

During any period of FMLA leave, the University must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work, provided the employee makes timely payment of the employee's share of the premiums.

Upon return to work, most employees must be restored to their original or equivalent positions with equivalent pay, benefits and other employment terms, unless the employment would have ended even if the employee had not been on leave (for example, if the job has been eliminated due to a staff reduction or reorganization). Use of FMLA leave cannot result in the loss of any employment benefits that accrued prior to the start of an employee's leave.

During any paid portion of the leave, the employee's premiums will continue to be deducted from payroll; otherwise, payments must be delivered to Human Resources by the normal pay date on which the premiums would have been deducted. Failure to make premium payments may cause the employee (and covered dependents) to be uninsured during a portion of the leave. Coverage terminated due to non-payment of premiums while on leave is not a COBRA qualifying event. Sick, vacation, and holiday will accrue during the FMLA leave.

If the employee fails to return to work for at least thirty (30) days at the end of the approved leave, the employee will be obligated to repay to the University 100% of all benefit premiums paid by the University during the unpaid portion of the leave. The only exception is where the non-return to work is due to a continued serious health condition (medical certification is required) or other circumstances beyond the employee's control.

Unable/Decline to Return

An employee who is unable or declines to fully return to work upon expiration of FMLA leave and has exhausted all other leave will be considered to have resigned, unless the inability to return is due to a disability under the Americans with Disabilities Act and the employee requests, and can reasonably be granted, some additional accommodation.

DEFINITIONS

"Foster care" is defined as 24-hour care for children in substitution for, and away from, their parents or guardian, in accordance with a placement made by the State or in agreement with the State.

"Spouse" is defined as a husband or wife as recognized under state law.

"Parent" is defined as a biological parent, or an individual who stood in loco parentis (had day-to-day responsibilities to care for the employee) when the employee was a child. A parent "in-law" is not considered a "parent" for purposes of family and/or medical leave.
"Son" or "daughter" or "child" is defined as a biological, adopted, or foster child, a stepchild, a legal ward, or a child of a person standing in loco parentis (has day-to-day responsibilities to care for and financially support the child). The "son" or "daughter" or "child" must be either under age 18, or age 18 or older and incapable of self-care because of a mental or physical disability.

A "serious health condition" is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities. Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than three (3) full consecutive calendar days combined with at least two (2) visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment. Absent complications or inpatient care, "serious health condition" generally does not include the cosmetic treatments, minor conditions such as the common cold, earaches, headaches, the flu, and so forth, routine doctor's appointments, or treatment with over-the-counter medicines.

A "health care provider" for purposes of medical certification shall include doctors of medicine or osteopathy, podiatrists, dentists, clinical psychologists, optometrists, chiropractors, state-authorized nurse practitioners, nurse-midwives, clinical social workers, state-authorized physician assistants, and Christian Science practitioners listed with the First Church of Christ, Scientist in Boston, Massachusetts.

A certification that an employee is "needed to care for" a sick family member includes both physical and psychological care. It includes situations where the family member is unable to care for his or her own basic medical, hygienic, or nutritional needs or safety, and where providing psychological comfort will be beneficial to a seriously ill family member.

Intermittent or reduced schedule leave is "medically necessary" when the medical need can be best accommodated through an intermittent or reduced leave schedule. The term "medically necessary" does not include voluntary treatments or procedures.

An "equivalent position" is defined as a position which has the same pay, benefits and working conditions; involves the same or substantially similar duties and responsibilities which entail equivalent skill, effort, responsibility and authority; is available at the same or a geographically proximate worksite where the employee had previously been employed; and is on the same or an equivalent work schedule.

Leave for the birth of a child may include necessary prenatal care, or may begin before the actual date of birth of a child if the expectant mother's condition makes her unable to work. Leave for placement of a child may begin before actual placement if an absence from work is required for the placement to proceed.
**Notice of Leave**

Employees must provide at least thirty (30) days' advance notice of the need to take FMLA leave, when the need is foreseeable, to the appropriate University representative. When thirty (30) days' notice is not possible, the employee must provide notice as soon as practicable and must comply with the University's normal call-in procedures required for other absences. If less than thirty (30) days' notice is given, the employee must explain why providing timely notice was not practicable.

Notice must be provided either in writing (for foreseeable leave only) or by calling (for either foreseeable or unforeseeable leave). When requesting leave for the first time for a particular FMLA-qualifying reason, the employee must provide sufficient information for the University to determine if the leave may qualify for FMLA protection, and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform essential job functions; the family member is unable to perform daily activities, the need for hospitalization, or continuing treatment by a health care provider. Calling in "sick" is not enough.

Employees must also inform the appropriate University representative if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

The University must inform employees requesting leave whether they are eligible under the FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities with regard to FMLA leave. If an employee is not eligible, the University must provide a reason for the ineligibility. The University will generally notify an employee within five (5) business days whether he/she is eligible for FMLA leave.

**Medical Certification**

An employee on leave due to a serious health condition of the employee or a family member must provide a written medical certification on a form adopted by the University. This requirement may be waived by the Human Resources Department in cases of pregnancy or other situations where both the medical need and the timing of the leave are obvious. The certification must be provided prior to commencement of the leave when the need for leave is foreseeable; in any case, it must be provided within fifteen (15) days after it is requested. Failure to return the medical certification, absent unusual circumstances, will cause the University to deny the FMLA leave. Where the leave is due to the employee's own serious health condition, the employee must provide a copy of his or her current job description to the health care provider before obtaining the certification. A copy of the job description may be provided to the employee. The University may require a second and third opinion at its expense, in accordance with the Act.

The University shall notify the employee within five (5) days of receipt of a complete and sufficient medical certification whether the leave is FMLA-qualifying. If the University is unable to determine whether the leave is FMLA-qualifying because (a) the medical certification is incomplete or insufficient, or (b) the University requires a second or third opinion, it will notify the employee. The University shall notify the employee, in writing, if the medical certification is incomplete or insufficient, and state the information needed to cure the deficiency. The employee shall have seven (7) calendar days to cure the deficiencies, or FMLA leave will be denied.
Re-certification

Medical recertification must be provided within fifteen (15) days after requested by the University during the leave. For intermittent leave for continuing, open ended conditions, recertification may be requested every six (6) months. In addition, recertification may be requested when (1) there is a significant change in condition, (2) an extension of the leave is requested, or (3) the University receives information which casts doubt on the continuing validity of the certification.

Failure to Provide Notice/Certification

Failure to provide required notices or certifications may result in a delay in the leave of absence, or loss of the protections provided by the Family and Medical Leave Act.

Fitness for Duty Certification (release to return to work)

The University requires an employee to provide a sufficient fitness for duty certification at the time the employee returns to work. The certification must state that the employee can return to work and is able to perform all essential functions of the position. If the fitness-for-duty certification is insufficient or incomplete, the employee will not be permitted to return to work and will have seven (7) calendar days to cure the deficiencies. Failure to present a sufficient fitness-for-duty certification may cause the return to work to be denied.

For intermittent leave, the University may require a fitness-for-duty certification as often as every thirty (30) days if the health condition involves a contagious disease, or could reasonably affect the employee's, a co-worker's, or a third party's safety.

ADMINISTRATION AND INTERPRETATIONS

The FMLA makes it unlawful for any employer to:
- Interfere with, restrain, or deny the exercise of any right provided under the FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by the FMLA or for involvement in any proceeding under or relating to the FMLA.

An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer for enforcement. FMLA does not affect any federal or state law prohibiting discrimination, or supersede any state or local law or collective bargaining agreement which provides greater family or medical leave rights.

AMENDMENTS OR TERMINATION OF POLICY

This policy supersedes any previous written or unwritten University policy/procedure pertaining to the Family and Medical Leave Act. Creighton University reserves the right to modify, amend, or terminate this policy at any time, especially to comply with changes in state or federal law related to the provisions of family and medical leave.
PURPOSE

The University's policy on drug and alcohol use is designed to satisfy the requirements of the Drug-Free Schools and Communities Act. Consistent with its mission, the University is also concerned about the medical problems of alcoholism and drug abuse, especially when they affect an employee's attendance and performance on the job. Alcoholism and drug dependence are treatable illnesses, and as such, employees whose job performance is adversely affected by such illnesses should seek diagnosis and treatment.

POLICY

A. Standards of Conduct / Disciplinary Sanctions

Creighton University standards of conduct prohibit the unlawful possession, use, or distribution of illicit drugs and/or alcohol by students and employees on University property or as part of any of the University’s activities. “Illicit drug use” means the use of illegal drugs and the abuse of other drugs and alcohol, including anabolic steroids. State and federal laws, and any applicable city ordinances, pertaining to the possession and use of illicit drugs and alcoholic beverages shall be observed by all University students and employees. By way of illustration, this means that it is a violation of University policy for students or employees to unlawfully purchase, manufacture, possess, consume, use, sell or otherwise distribute such items on campus or during University activities.

Employee violations of the standards of conduct stated in the above paragraph shall result in disciplinary sanctions as stated in the Handbook for Faculty or Staff Handbook, as the case may be, and/or as stated below, which may include, but are not limited to:

--Warning;
--Disciplinary probation;
--Suspension;
--Termination of employment;
--Referral to an appropriate drug/alcohol treatment program; and/or;
--Any other action considered necessary or appropriate by University officials, including referral to law enforcement officials for prosecution.
B. Health Risks

Numerous health risks have been identified with substance abuse (use of illicit drugs and abuse of alcohol). Some of those health risks are discussed in APPENDIX A.

C. Treatment for Drug and/or Alcohol Problems

Different health insurance plans offer different levels of coverage for counseling and treatment of drug and alcohol problems. Refer to the description of your plan for specific levels of coverage for these services.

D. Legal Prohibitions and Sanctions

1. State Prohibitions (Section References are to Nebraska State Statutes)
   a. Except as authorized by the Uniform Controlled Substances Act, it is unlawful to knowingly or intentionally manufacture, distribute, deliver, or dispense a controlled substance, or possess with intent to manufacture, distribute, deliver, or dispense a controlled substance. Sec. 28-416(1).
   b. Depending on the controlled substance involved and its quantity, violation of paragraph (1) with respect to a scheduled controlled substance can be a Class II, Class III, or Class IV felony, except as provided in paragraphs (3) and (4) below. Sec. 28-416(2).
   c. Any person who violates paragraph (1) with respect to cocaine or any mixture or substance containing a detectable amount of cocaine in a quantity of:
      1. 7 or more ounces is guilty of a Class IC felony; or
      2. At least 1 ounce but less than 7 ounces is guilty of a Class ID felony. Sec. 28-416(4).
   d. Any person who violates paragraph (1) with respect to base cocaine (crack) or any mixture or substance containing a detectable amount of base cocaine in a quantity of:
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1. 28 grams or more is guilty of a Class IC felony; or

2. At least 10 grams but less than 28 grams is guilty of a Class ID felony. Sec 28-416(5).

e. Any person knowingly or intentionally possessing a controlled substance (other than marijuana), unless obtained directly from or by prescription or order from a practitioner while acting in the course of his/her practice, or except as otherwise authorized by the Controlled Substances Act, is guilty of a Class IV felony. Sec. 28-416(3).

f. Any person knowingly or intentionally possessing marijuana weighing more than 1 ounce but not more than 1 pound is guilty of a Class IIIA misdemeanor. Sec. 28-416(6).

g. Any person knowingly or intentionally possessing marijuana weighing more than 1 pound is guilty of a Class IV felony. Sec. 28-416(7).

h. Any person knowingly or intentionally possessing marijuana weighing 1 ounce or less is:

1. For the first offense, guilty of an infraction, receives a citation, may be fined $100 and may be assigned to attend a drug abuse course of instruction.

2. For the second offense, guilty of a Class IV misdemeanor, receives a citation, and may be fined $200 and imprisoned not to exceed 5 days.

3. For the third and all subsequent offenses, guilty of a Class IIIA misdemeanor, receives a citation, and may be fined $300, and imprisoned not to exceed 7 days. Sec. 28-416(8).

i. Any person who is under the influence of any controlled substance, for a purpose other than the treatment of a sickness or injury as prescribed or administered by a person duly authorized by law to treat sick and injured human beings, is guilty of a Class III misdemeanor. Sec. 28-417.
Policies and Procedures

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j. It is a Class IV felony to knowingly or intentionally: (a) acquire or attempt to acquire a controlled substance by theft, misrepresentation, fraud, forgery, deception or subterfuge; (b) possess a false or forged prescription for a controlled substance; or (c) communicate information to a practitioner in an effort to unlawfully procure a controlled substance or a prescription for a controlled substance. Sec. 28-418.

k. No person may sell, give away, dispose of, exchange, or deliver, or permit the sale, gift, or procuring of any alcoholic liquors, to or for any person under the age of 21. Sec. 53-180. This is a Class I misdemeanor. Sec. 53-180.05.

l. No one under the age of 21 may obtain, or attempt to obtain, alcoholic liquor by misrepresentation of age, or by any other method, in any place where alcoholic liquor is sold. Sec. 53-180.05.

m. No one under the age of 21 may sell of dispense or have in his or her possession or physical control any alcoholic liquor in any tavern or in any other place including public streets, alleys, roads, highways, or inside any vehicle. Sec. 43-180.02. This is a Class III misdemeanor. The offender may also be required to work on streets, parks, or other public property for up to 10 days. Sec. 53-180.05.

n. Any person who knowingly manufactures, creates, or alters any form of identification for the purpose of sale or delivery of such form of identification to a person under the age of 21 is guilty of a Class I misdemeanor. Sec. 53-180.05.

2. Sanctions Under State Law

Class I Misdemeanor: Maximum - Not more than 1 year imprisonment, or $1,000 fine, or both.

Class III Misdemeanor: Maximum - 3 months imprisonment, or $500 fine, or both.

Class IIIA Misdemeanor: Maximum - 7 days imprisonment, or $500 fine, or both.

Class IV Misdemeanor: Maximum - $500 fine; Minimum - $100 fine.
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<td>Class III</td>
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<td>-20 years imprisonment</td>
<td>$25,000 fine, or both</td>
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<td>-5 years imprisonment</td>
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3. Federal Prohibitions and Sanctions

A variety of federal statutes also prohibit the unlawful possession or distribution of illicit drugs. The federal prohibitions and sanctions are discussed in APPENDIX B.

### SCOPE

This policy applies to all University employees and employees of contractors to the University, to all students, and to campus visitors, as well.

In addition, any employee who accepts or performs University employment which involves direct engagement in work under any federal grant or federal procurement contract,* is hereby notified that, as a condition of employment in such grant or on such contract, he or she must abide by the terms of this policy. In addition, any such employee must notify the University’s Human Resources Director of any criminal drug statute conviction, for a violation occurring in a grant or contract workplace, no later than five days after such conviction. Upon receipt of such notice, the University will, where required by the Act:

1) take appropriate personnel action against the employee, which may include actions up to and including termination; or,
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**POLICY:**

Drug and Alcohol Use

2) require such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by federal, state, or local health, law enforcement or other appropriate agency.

* a contract awarded to the University by any federal agency for the procurement of any property or services of a value of $25,000 or more, or, a grant made to the University by any federal agency. Employees found to be in violation of this policy will be subject to any consideration for rehabilitation and/or disciplinary action, including possible termination of employment.

**DEFINITIONS**

**Illicit drug use:** means the use of illegal drugs and the abuse of other drugs and alcohol, including anabolic steroids.

**ADMINISTRATION AND INTERPRETATIONS**

Questions related to Creighton University’s policy on drug and alcohol use can be directed to the Department of Human Resources and its Director.

**AMENDMENTS OR TERMINATION OF THIS POLICY**

Creighton University reserves the right to modify, amend, or terminate this policy at any time, especially to comply with changes in the Drug-Free Schools and Communities Act. Nothing in this policy should be construed as a contract between Creighton University and its employees.
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**POLICY: Control of Infectious Diseases**

**PURPOSE**

Creighton University's policy for the control of infectious diseases is aimed at underscoring the overall purpose of the University in producing graduates with the knowledge and skills to help them function as civilized, cultured women and men in society. The control of infectious disease helps to improve and preserve a society's quality of life. Therefore, as an educational institution, Creighton University will provide education to all members of the University community to prevent the transmission of infectious diseases. Creighton University will also provide for specific actions to control infectious disease in a manner that maintains the dignity and the safety of the individual.

To ensure that decisions implementing this policy reflect current understanding of infectious disease control, certain pertinent concepts and guidelines are included with this policy statement. These concepts and guidelines must be understood to apply this policy.

**POLICY**

**A. Education**

To ensure that information on methods of preventing the spread of infectious disease is available to all members of the Creighton community, the following mechanisms will be instituted:

1. *Informational sessions* will be required for all Creighton students and employees working in areas where isolation techniques and techniques for handling blood and other specimens must be employed.

2. Information on maintaining *adequate immunization* for vaccine-preventable disease will be communicated to all Creighton students, their parents, and Creighton employees.

3. *Methods of preventing non-vaccine preventable disease* will be provided to all Creighton community members through communication mechanisms such as newsletters, the university newspapers, seminars, etc.

4. Student Health and Counseling Center personnel will be provided to plan an *infectious disease control program for the campus* and to teach infectious disease concepts to students and employees such as resident hall directors, peer educators, and freshman seminar group leaders.
Professionals from the health science departments will be enlisted to teach infectious disease control to Creighton employees.

These educational efforts will be coordinated and facilitated by the Educational Subcommittee of the Healthy Lifestyles Committee with the support of the University.

B. Actions

To provide an environment for its faculty, staff, and students which minimizes the risk of acquiring or transmitting infectious disease, the following policies are adopted:

1. Creighton University reserves the right to require specific immunization status of employees and students who participate in University sponsored activities. Standard immunizations as recommended by the Centers for Disease Control will be required of all new employees and matriculating students. Additional specific immunizations will be required of Health Sciences workers and students as deemed appropriate by the Student Health Center and the deans of the respective Health Science schools.

2. Creighton University reserves the right to exclude from certain activities those members of the community (employees or students) identified with an infectious disease where transmission to others is a potential hazard.

3. Creighton University will refer, as appropriate, to providers of health care service for remedial action any person affiliated with the University, who has an inadequate or lapsed immunization status or who has been identified as exhibiting evidence of an infectious disease. Notification from a private physician, University clinic, or Student Health Service that the person no longer is a hazard to others will be required prior to return to assigned duties.

4. Creighton University will counsel, as appropriate, persons with infectious disease or those exposed to a known infectious disease, to adhere to established standards of behavior in order to minimize the risk of transmission of disease to others.

Exclusions, referrals, and counseling will be the responsibility of each school and/or department, and may require the cooperation and participation of one or more appropriate offices of the University.
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Such activity will be conducted in as discreet and confidential manner as is possible without sacrificing effectiveness. The privacy and confidentiality tenets as prescribed by Federal Law will be maintained.

5. Creighton University may modify, when appropriate, *general University housing regulations to accommodate appropriate living arrangements* for persons afflicted with an infectious disease or their roommates.

6. Creighton University will *limit the use of hypodermic needles, scalpel blades, and other sharp instruments which are used on humans* to those who observe public health recommendations for their use and disposal. These current recommendations will be published and distributed annually to all units of the University by the Healthy Lifestyles Committee.

7. Creighton University will request persons afflicted with an infectious disease to *disclose their medical condition* to other members of the community with whom they have had or are to have contact which could pose a risk of transmission of disease.

8. Creighton University will *publish these policies* in official University handbooks for students, staff, and faculty.

9. Creighton University will *direct all inquiries* about an infectious disease situation at the University to the Public Relations Director.

10. Creighton University will provide for the *annual review* of these policies by health professionals on the Healthy Lifestyles Committee.

Through these policies, the University endeavors to protect members of its community from unreasonable risk of acquiring or transmitting infectious disease. However, the University does not nor cannot insure or guarantee that such a situation will not occur in its environment. Obviously, the transmission of infectious disease can result from individual conduct over which the University has no control.

**References**

Control of Infectious Diseases

C. Understanding infectious diseases

1. A variety of infectious diseases exist. Some, like chicken pox, spread very easily. Others, even very serious ones like Hansen’s disease, spread with great difficulty. Some, like rabies, can be very severe. Others, like the common cold, are often very mild.

2. Some infectious diseases, like the acquired immunodeficiency syndrome (AIDS, caused by the human immunodeficiency virus or HIV), generate much concern. Others, like rubella, generate much less concern. Even though concern among the general public for some diseases may be small, health risks to the Creighton community may be large.

3. Control of an infectious disease can be conceptualized as involving any of three factors: a microorganism, a person susceptible to disease caused by that microorganism, and a means of transmitting the microorganisms to the person.

4. Examples of microorganisms causing diseases include Salmonella typhi (the cause of typhoid fever), mycobacterium tuberculosis (the cause of tuberculosis), polio viruses (the causes of poliomyelitis), the variola virus (the cause of smallpox). An example of control of an infectious disease by control of a microorganism is the elimination of smallpox by the eradication of variola virus. This is the only case in which humanity has controlled an infectious disease by eliminating the virus that causes it. Most viruses are too widespread and too persistent for such a strategy to succeed.
5. *Examples of persons susceptible to a disease* include persons with no history of poliomyelitis and no immunization against poliomyelitis (who would be susceptible to poliomyelitis). An example of the control of an infectious disease by *control of the population of persons susceptible to that disease* is the near-elimination of poliomyelitis from the United States. Vaccine against polio viruses was used to immunize a large number of persons. These persons were no longer susceptible to poliomyelitis. Widespread immunization has so reduced the population of susceptible persons that poliomyelitis has been nearly eliminated. Vaccines can be valuable, but sometimes are not used and for some infectious diseases are unavailable.

6. *Examples of means of transmission of disease* include swallowing of a sufficient quantity of *S. typhi* by a nonimmune person to produce typhoid fever and inhalation of a sufficient quantity of *M. tuberculosis* by a nonimmune person to produce tuberculosis. An example of the control of an infectious disease by *control of the means of transmission* is the prevention of typhoid fever by rules of sanitary food preparation that exclude feces, which are the body material that transmits *S. typhi*, from food that is being prepared. To control an infectious disease by controlling its means of transmission, rules of prevention must deal specifically with the particular means of transmission. Rules of sanitary food preparation may, in general, be laudable. However, they would not prevent airborne transmission of tuberculosis.

7. Creighton University may encounter certain appropriate opportunities to prevent certain infectious diseases. *A decision to act to prevent an infectious disease requires knowledge of three general characteristics of the disease:*

   a. What *microorganism* causes the disease?
   b. How can *susceptible individuals* be identified?
   c. How is the microorganism *transmitted* to a susceptible individual?

   A decision also requires *knowledge of three characteristics of individuals who may be affected by the disease:*

   d. Will the individual be in *proximity* to the microorganism?
   e. Is the individual *susceptible* to the microorganism?
   f. Will the individual *engage in the particular type of activity* through which the microorganism is transmitted?
8. An example of an opportunity to prevent an infectious disease is the prevention of hepatitis B in dental students. Knowledge about hepatitis B in general includes:

a. Hepatitis B virus causes it.
b. Tests on the blood of individuals can identify an absence of antibodies to the virus, which indicates susceptibility. Alternatively, epidemiological studies provide good indication of the likelihood of hepatitis B susceptibility in populations such as dental students.
c. Hepatitis B is transmitted in a variety of ways. An important one is from blood and saliva of an infected dental patient through an inadvertent puncture wound of the hand of a dental student to that student.

Knowledge about hepatitis B and a typical dental student includes:

d. Epidemiological studies suggest that dental students at Creighton are likely to encounter patients carrying the hepatitis B virus.
e. Epidemiological studies suggest that most Creighton dental students would be susceptible to the hepatitis B virus.
f. Clinical work required of Creighton dental students is likely to result in wound transmission of hepatitis B virus.

This knowledge might lead to any of a number of approaches. Perhaps blood tests might be performed on Creighton dental students at various stages to confirm epidemiological studies suggesting susceptibility. Perhaps students, as a condition of matriculation, might be required to submit results of a blood test demonstrating immunity to hepatitis B virus or to be immunized against hepatitis B virus.

9. At this University, and elsewhere, there has been much scholarly investigation in infectious diseases. Decisions about measures to control infectious diseases must reflect up-to-date medical knowledge. In general, such decisions can be assisted by considering the advice of organizations like the Centers for Disease Control, Nebraska public health authorities, and the American College Health Association. Health sciences professionals of the University are ready to assist in the interpretation of such advice.
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10. The “Statement of Goals and Common Objectives in the Health Sciences” affirms: “With respect to the worth and dignity of the person whose health is the ultimate object of all Health Sciences activity: The members of the Creighton Health Sciences community recognize that the good of the person takes priority over all other goals...” Decisions to control infectious diseases may at times exclude an individual from certain activities. In general, decisions to exclude must reflect a concatenation of three factors: (1) harboring of a microorganism by the individual; (2) the presence of susceptible persons; and (3) a means of transmission of the microorganism from the individual to the susceptible persons in the course of the activities. In general, such decisions must be made on a case-by-case basis, reflecting the advice of national and state public health authorities.

**References**


Xavier University, Cincinnati, Ohio. *Policy and procedures statement for communicable diseases*.

**D. Immunization policy for Creighton students**

All Creighton University students, full-time and part-time, are required to be properly immunized for rubeola (measles) beginning April of 1990, and all full-time students are required to be properly immunized against rubella (German measles) and mumps prior to registration for classes beginning with the Autumn semester, August, 1988. Immunization forms must be signed by a physician or school nurse. Those persons submitting incomplete or incorrect immunization information will be notified and their registration will be held until they have complied. A nominal fee for administration of an immunization will be placed on the tuition bills of those students who have not complied with the immunization requirement prior to registration.
According to the recommendations of the Immunization Practices Advisory Committee (ACIP) of the Centers for Disease Control immunity to rubeola (measles), rubella (German measles), and mumps is defined as follows:

**Rubeola (measles)** - Two doses of measles vaccine is required for all students born after 1956.

1. Measles vaccine administered after 1967 and given after one year of age (specify month and year); AND
2. Measles vaccine administered after 1979 (specify month and year); OR
3. Born before 1957, therefore considered immune; OR
4. Physician diagnosed measles with M.D. certified data including month and year; OR

**Rubella (German measles)**

1. Rubella vaccine administered after 1967 and given after one year of age (specify month and year); 
2. Born before 1957, therefore considered immune. 
4. History of disease is not accepted.

**Mumps**

1. Born before 1957, therefore considered immune; 
2. Mumps vaccine administered after 1967 and given after one year of age (specify month and year); OR
3. Physician diagnosed mumps with M.D. certified data including month and year; OR

Also required. (Presently registration will not be held for noncompliance except for international students and health science students - Dental, Medical, Nursing, and Allied Health)
1. Tuberculin Skin Test (PPD) with date (month and year) including test results is required. If the PPD is positive, a chest x-ray with date (month and year) including test results is required. If the student had BCG, a negative PPD or chest x-ray is required with date (month and year) including test results.

2. Tetanus booster or Tetanus-diphtheria which includes month and year. Tetanus or Tetanus-diphtheria must have been given within the past ten years.

3. Essential for appropriate preventive care:
   Polio: completion of primary series with:
   OPV (oral Sabin) - total of 3 doses
   OR
   IPV (injected Salk) - total of 4 doses

Note: if not completed in the past, primary polio immunization is essential before travel to an area endemic or epidemic for polio.

Required for Health Science students (Dental, Medical, and Nursing). The cost of the vaccination will be added to tuition. Recommended for Pharmacy and Allied Health students.

1. Hepatitis B vaccine
   OR

E. Creighton University general guidelines for responding to the AIDS situation

Preface: People with HIV infection may be healthy, but have evidence of the infection because of the presence of an antibody to the virus in their blood; others have a condition meeting the criteria of the surveillance definition of AIDS itself, or one of the lesser symptomatic manifestations of infection. Current knowledge indicates that students or employees with any form of HIV infection do not pose a health risk to other students or employees in an academic setting (Centers for Disease Control, 1987). HIV is transmitted by intimate sexual contact or by exposure to contaminated blood. Although HIV can be found in many body secretions of those who are infected, its presence is correlated with disease transmission only through blood, semen, and female genital secretions. There has been no confirmed case of transmission of HIV by any household, school, or other casual contact (Friedland & Klein, 1987).
The Public Health Service states that there is no risk created by living in the same place as an infected person; being coughed or sneezed upon by an infected person; casual kissing; or swimming in a pool with an infected person (American College Health Association [ACHA], 1988, at B).

GUIDELINES (Recommended by the American College Health Association)

1. Consideration of the existence of any form of HIV infection will not be a part of the initial admission decision for those applying to attend the institution (ACHA, 1988, at C.4) or for those seeking employment at the institution.

2. Creighton University will not undertake programs of screening newly admitted or current students for antibody to HIV; neither will mandatory screening of employees be implemented. The University will not attempt to identify those in high-risk groups and require screening only of them (ACHA, 1988, at C.9a).

3. Creighton University students who have HIV infection, whether they are symptomatic or not, will be allowed regular classroom attendance in an unrestricted manner so long as they are physically and mentally able to attend classes (ACHA, 1988, at C.5).

4. Creighton University supports the American College Health Association (ACHA) statement that there is no justification, medical or otherwise, for restricting the access of students or employees with HIV infection to student unions, theaters, restaurants, cafeterias, snack bars, gymnasiums, swimming pools, recreational facilities, or other common areas (ACHA, 1988, at C.6).

5. Creighton University is in agreement with the American College Health Association s statement that there is no medical necessity for institutions to advise students living in a dormitory of the presence in the dormitory of other students who have HIV infection (ACHA, 1988, at C.10e).

Decisions about residential housing of students with HIV infection will be made on a case-by-case basis. The best currently available medical information does not indicate any risk to those sharing residence with infected individuals, there may, however, be in some circumstances reasonable concern for the health of those with immune deficiencies (of any origin) who might be exposed to certain contagious diseases (e.g., measles or chicken pox) in a close living situation (ACHA, 1988, at C.7).
6. Creighton University will educate the University community on the AIDS situation through workshops, seminars, and the availability of literature. Creighton University will make available the latest information from the Public Health Service concerning measures to prevent the transmission of the AIDS virus as far as they reflect the moral and ethical standards of the University.

7. Creighton University will adopt safety guidelines for the handling of blood and body fluids of all persons (ACHA, 1988, at C.11). Laboratory courses requiring exposure to blood, such as finger pricks for blood typing or examination, will use disposable equipment and no lancets or other blood-letting devices will be reused or shared (ACHA, 1988, at C.11.c). No student, except those involved in health care professions within a health care course, will be required to obtain or process the blood of others. All contaminated surfaces will be cleaned with a household bleach freshly diluted 1:10 in water as recommended by the Public Health Service (ACHA, 1988, at C.11.a).

8. Creighton University will adopt safety guidelines as proposed by the Public Health Service for handling of blood and body fluids of all persons for students involved in health care professions within a health course (in a clinical laboratory setting). (ACHA, 1988, at C.11.b.1).

9. In accordance with the recommendations of the American College Health Association, Creighton University:
   a. will not ask current students or employees to respond to questions concerning the existence of HIV infection (ACHA, 1988, at C.8a);
   b. will encourage new students through the University Health Form and new employees to respond to questions about the existence of HIV infection. This information, like any other medical information, will be handled in a strictly confidential manner (ACHA, 1988, at C.8.a).

10. The handling of confidential medical information about people with HIV infection will follow the general standards included in the American College Health Association’s Recommended Standards and Practices for a College Health Program, Fourth edition, 1984 (ACHA, 1988, at C.10.a):
In general, no specific or detailed information concerning complaints or diagnosis will be provided to faculty, administrators, or even parents, without the expressed written permission of the patient in each case. The position with respect to health records is supported by amendment to the Family Education Rights and Privacy Act of 1974.

11. Creighton University’s health policy will encourage regular medical follow-up for those who have HIV infection (ACHA, 1988, at C.8.b).

12. Those who are known to be immunologically compromised will be excused from institutional requirements for certain vaccinations, notably measles and rubella vaccines (ACHA, 1988, at C.8.d).

13. Creighton University’s Health Service will:

   a. remain familiar with sources of testing for antibody to HIV and be able to refer students or employees requesting such testing (ACHA, 1988, at C.9.b);

   b. use disposable, one-user needles and other equipment whenever such equipment punctures the skin or mucous membranes of patients (ACHA, 1988, at C.11.b.2); and

   c. will observe health reporting requirements for AIDS (ACHA, 1988, at C.10.f).

References

Bradley University. *General guidelines for responding to the AIDS situation*.


APPENDIX A

For infection control and epidemiology purposes, all employees are screened for selected infectious diseases and must participate in required education programs upon employment and annually.

Pre-Employment

1) Past history of Varicella or documentation of positive titer. If unknown, Varicella titer is done.

2) Past history of Mumps or documentation of adequate immunization or positive titer.

3) Past history of Rubella or documentation of adequate immunization or positive titer. If unknown, Rubella titer is done. If negative, vaccination is required unless contraindicated.

4) Rubeola
   a) If born before 1957, past history of Rubeola or documentation of adequate immunization or positive titer.
   b) If born 1957 or later, documentation of adequate immunization. Must have had two immunizations after 12 months or positive titer. If unknown, rubeola titer is done. If negative, vaccination is required unless medically contra-indicated.

5) PPD -- If history of past positive skin test, then chest x-ray is done. May omit if skin test was previously positive and chest x-ray was negative at that time.

6) Hepatitis B -- Documentation of complete Hepatitis B vaccine series if identified versus having occupational exposure to bloodborne pathogens. If no history, vaccination is offered. Hepatitis B surface antigen testing is done if vaccination completed within last two years and no antibody done. If vaccination is refused, waiver must be signed.

7) Bloodborne pathogen training as required by OSHA.

8) Infection control education is required by Joint commission for those employees in medical clinics or other areas determined by Human Resources.

Annual

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<th>POLICY:</th>
<th>Tobacco-Free Policy</th>
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**PURPOSE**

Creighton University is dedicated to providing a healthy, comfortable, and productive living and work environment for our faculty, staff and students and a healthy, comfortable, and safe environment for our visitors.

**POLICY**

Due to the acknowledged health hazards arising from tobacco products, including exposure to secondhand smoke, it shall be the policy of Creighton University to provide a tobacco-free environment for all faculty, staff, students and visitors beginning July 1, 2008. This policy covers tobacco of any kind, including the use of smokeless or “spit” tobacco and applies to all faculty, staff, students and visitors of Creighton University.

1. **There will be no tobacco use in or on any Creighton facility or property, owned or leased, at any time.** The only exception will be all Creighton University approved research studies involving tobacco-use.

2. **There will be no tobacco use in any Creighton University vehicle at any time.**

3. **The sale of tobacco products on campus is prohibited.** The availability of tobacco products in campus stores serves only to reinforce the notion that tobacco use is socially normative, sanctioned adult behavior. It would be hypocritical for Creighton University to take a stand against tobacco use but profit by allowing the sale of tobacco on its campus.

4. Campus organizations are prohibited from accepting money or gifts from tobacco companies. **Nothing in this policy will prohibit the University from accepting Nebraska Tobacco Settlement Trust Fund money, or money from any other governmental entity which was generated from tobacco litigation or tobacco taxes, and which is intended to be used to fund tobacco cessation or other research projects at the University.**

5. **Tobacco advertisements are prohibited in University-sponsored publications.**

**DEFINITION**

“Tobacco” and “tobacco products” includes tobacco of any kind, including the use of smokeless or “spit” tobacco.

**PROCEDURE**

1. A robust, comprehensive internal communication effort will be undertaken to inform faculty, staff, and students of this policy through formal and informal communication systems such as e-mail, the Web, posters, meetings, mailings and more.
Copies of this policy shall be distributed to all faculty, staff and students. Signs will also be posted throughout the Creighton University facilities, grounds, and vehicles. This policy will be added to the policy and procedures manual, and it will be covered in orientation and training for all faculty, staff, and students.

2. Visitors will be informed of this policy through signs posted at all entrances to all Creighton University facilities.

3. Creighton University is committed to providing support to all faculty, staff, and students who wish to stop using tobacco products. Creighton University will ensure that Creighton faculty, staff and students have access to several types of assistance, including over-the-counter tobacco cessation medications, prescribed cessation medication and group counseling services. Supervisors are encouraged to refer their personnel to the cessation services for which they are eligible. Students will be offered an internet-based tobacco cessation program that will include stage-matched messages, interactive personalized assessment, ask-the-expert dialogue, and opportunities to share experiences about their tobacco use through discussion boards or personal story areas.

4. All contractors will be informed of the tobacco-free policy through a clause in their contracts.

5. Faculty, staff and students are encouraged to champion this initiative and to directly and politely educate those unaware of the policy, or remind those who disregard it. Sensitivity needs to be displayed at all times and talking points and messaging will include these points. Disciplinary procedures during the first year of implementation of this policy will be primarily education and counseling. However, if efforts are unsuccessful during the second year of implementation of this policy, individuals in violation of this policy will be subject to disciplinary actions as defined by Creighton University policies. Each faculty, staff, and student found in violation of the policy will be referred to Creighton University’s Commit to Quit program developed and offered through the Cardiac Center of Creighton University. When an individual who is using tobacco is observed by a public safety officer, the officer may inform the tobacco user of the policy and request him/her to cease using tobacco. In the case of a visitor who ignores the public safety officer’s request, the officer may escort the visitor off campus. Extensive training on handling these situations is planned for key staff.

6. This policy becomes effective July 1, 2008. The success of this policy will depend on the thoughtfulness, consideration, and cooperation of both tobacco users and non-tobacco users. All Creighton faculty, staff and students share in the responsibility for adhering to and enforcing this policy. All faculty, staff, students, and visitors have a right and an obligation to request a tobacco user to extinguish their tobacco product and explain Creighton University’s tobacco-free campus policy.
PURPOSE

This policy applies to all University-sponsored events at which alcohol is served. It also includes faculty or staff sponsored University-related social events on or off campus at which alcohol is served. Both types of events shall be referred to as “University Events” in this policy. This policy applies to all University events, whether students are present or not.

POLICY

1. For all University events at which alcohol is served, the host of the event (either Creighton or a faculty or staff member, as the case may be), must make available nonalcoholic beverages in addition to the alcoholic beverages. Creighton desires to encourage the responsible use of alcohol at all such events and making alternative beverages available supports this goal.

2. For all University events at which alcohol is served, the person or persons serving the alcohol are required to make identification checks of any person who may be underage to prevent any underage drinking. Diligent checking of identification is Creighton’s only means of ensuring compliance with state law.

3. The University strongly encourages all of its employees to use alcohol responsibly at all times, but particularly at University events because of the damage which may be done to Creighton’s reputation, and the poor example it sets for other employees and for students. Creighton desires to achieve a community where moderation, safety, and individual accountability for those who choose to drink are the norm.

SCOPE

This policy applies to all University employees.

PROCEDURES

The Vice President for Student Services and the Senior Vice President for Operations shall jointly supervise the implementation of this policy. It is their responsibility to ensure that bartenders serving alcohol at University-sponsored events be required to demand identification from all persons who possibly could be underage.
It is the responsibility of individual supervisors to communicate this policy to their employees. In addition, supervisors may have to counsel employees whose behavior indicates a lack of awareness of this policy. If any employee of the University does not adhere to this policy because of irresponsible drinking or, if such a person acts as a host of an event and fails to demand identification of all persons who may possibly be underage, discipline action outlined in the Progressive Discipline Policy may be administered by the employee’s supervisor according to his/her discretion.

ADMINISTRATION AND INTERPRETATIONS

For guidance in administering and interpreting this policy, supervisors may contact the University’s Human Resources Department. Student policies on alcohol may be found in the University’s Student Handbook. For guidance in administering and interpreting policies pertaining to students within the Student Handbook, contact the Vice President for Student Services.

AMENDMENTS OR TERMINATION OF THIS POLICY

Creighton University reserves the right to modify, amend, or terminate this policy at any time.
**PURPOSE**

Creighton University expects all employees to assume responsibility for their attendance and promptness. The University also recognizes that a reasonable amount of absence due to illness and/or emergency situations is beyond the control of the employee. This policy does not apply to situations involving a pre-approved absence.

**POLICY/PROCEDURES**

1. It is the responsibility of each employee to notify his or her immediate supervisor as soon as possible if he/she will be late or absent from work for any reason. The employee will notify the supervisor daily if the absence continues, unless a formal leave of absence is granted.

2. The employee must indicate the reason for his/her absence and its probable duration.

3. Excessive absenteeism/tardiness may result in disciplinary action, up to and including termination. The definition of "excessive" rests with department supervisory personnel in collaboration with Human Resources based upon the operational requirements of the work unit. Excessive absenteeism/tardiness will be determined on a case-by-case basis considering such factors as the frequency, cause and patterns of absenteeism/tardiness regardless of the employee's accumulated sick and/or vacation hours.

4. An employee who is absent for three consecutive days without contacting his/her supervisor will be considered to have voluntarily terminated his/her employment at Creighton University.

5. The University reserves the right to request a certificate from an employee's health care provider during or following the illness of an employee.

6. Each supervisor is responsible for keeping accurate records of an employee's attendance. This includes the accurate preparation and submission of time reports to Payroll.

**SCOPE/ELIGIBILITY**

This policy applies to all University employees except faculty.
PURPOSE

Creighton University strives to offer a harmonious and orderly work environment that promotes respect among employees and supports efforts to achieve the highest level of professionalism. All employees are expected to adhere to established standards of conduct and performance.

SCOPE/ELIGIBILITY

This policy applies to all employees in Levels A through M.

POLICY

The University expects employees to follow standards of conduct that will protect the interests and safety of all students, patients, visitors and employees. Conduct that is offensive and discredits the University interferes with business operations. Employees are expected to satisfactorily complete duties in a business-like manner and assume responsibility for performance and conduct.

Guidelines for supervisors regarding acceptable employee behavior:

- Employee performance expectations should be clearly set forth in the Position Information Questionnaire (PIQ) and annual performance evaluation. When performance problems occur, the preferred disciplinary approach will focus on solving the problems through a process of corrective counseling, if possible and practical.
- The corrective counseling process will center on communicating an expectation of change and improvement while also informing the employee of the consequences for non-improvement.
- Corrective counseling will focus on identification of areas in which employee’s performance needs improvement.
- In administering this policy, application of the corrective action will be properly documented and applied consistently, objectively and fairly.

Guidelines for employees regarding acceptable behavior:

- Employees should strive to perform all duties as set out in the PIQ and annual performance evaluation, maintain a record of excellence and adhere to the University’s policy regarding performance and conduct.
- Cooperate on two-way communication with supervisors regarding performance and conduct issues.
- Seek clarification from supervisors to prevent performance or conduct issues in situations where rules or standards may be unclear to the employee.
When corrective counseling fails or its use is deemed not appropriate by the University, it is important that supervisors follow the formal disciplinary steps described below.

Except as set out in Procedure 7, supervisors may not implement any disciplinary steps of this policy without first consulting with the Employee Relations Administrator. Extenuating circumstances may require a supervisor to take immediate action to maintain a safe environment.

Each situation will be addressed on an individual basis and may include consultation with the applicable Vice President and/or the Office of the General Counsel at the discretion of the Employee Relations Administrator.

**PROCEDURES**

1. It is the duty and responsibility of every employee to be aware of and abide by existing policies and procedures. Supervisors are encouraged to assist employees in obtaining copies of policies and procedures through websites such as: [www.creighton.edu/President/PresOfc/GuideToPolicies/Guide](http://www.creighton.edu/President/PresOfc/GuideToPolicies/Guide) or contact a Human Resources representative. In addition, a copy of the “Guide to Policies of Creighton University” is available for viewing at each University library location.

2. Every employee is responsible for the satisfactory performance of assigned duties, as stated in the Position Information Questionnaire (PIQ). A copy of the PIQ may be obtained from the employee’s supervisor.

3. Employees are encouraged to request additional job-related training when needed. Likewise, supervisors are encouraged to make time available for employees to attend appropriate learning opportunities.

4. Creighton University supports progressive discipline as a method of addressing employee issues such as unsatisfactory work performance or misconduct. The University has adopted the following guidelines for use by supervisors in most situations. Nothing stated in this policy or elsewhere is intended to create a contract of employment, or to modify the status of persons who are otherwise “at will” employees.

a. The corrective counseling process will include warnings coordinated through the Employee Relations Administrator, prior to presentation to the employee to explain the unacceptable behavior/performance. The University reserves the right to accelerate actions based upon the severity of the circumstances. The following steps are to be used as a guideline:

   1) A verbal warning is used when the supervisor verbally counsels an employee. A written record of the discussion, acknowledging receipt by the employee's signature, noting the date, event and specific corrective action will be prepared by the supervisor. It will also be noted on the original document that a copy will be placed in the employee’s official personnel file in the Human Resources Department.
2) A formal written warning is used for behavior or violations a supervisor considers serious or as a follow-up when a verbal warning has not helped to remedy/improve the unacceptable performance and/or conduct. A written warning, acknowledging receipt by the employee’s signature, noting the date, event and specific corrective action will be prepared by the supervisor. It will also be noted on the original document that a copy will be placed in the employee’s official personnel file in the Human Resources Department.

3) The University may require the employee to participate in a Performance Improvement Plan (PIP) not to exceed 90 days. Within the PIP, the employee must demonstrate a willingness and ability to meet and maintain established work performance and/or conduct requirements. At the end of the PIP, the employee will either be returned to regular employment status or terminated. If, at any time during the PIP, the employee does not demonstrate significant and consistent improvement, the employee may be terminated before the conclusion of the PIP at the discretion of the University.

4) In addition, in those cases where appropriate, a suspension of employment up to three days, with or without pay, may be implemented by the University for the purpose of conducting an investigation. Following an investigation, an employee will be informed of the results of the investigation and of the next actions to be taken up to and including termination.

5. An employee may utilize any of the following options available to assist in resolving any performance or conduct issue:

a. An employee may submit a written response to any performance and/or conduct action within three business days of the action taken. A written response should be submitted to the supervisor and to the Employee Relations Administrator for placement in the employee’s official file.

b. An employee may contact the Employee Relations Administrator to confidentially discuss the situation or to request a meeting with the supervisor or the supervisor’s supervisor if deemed appropriate or helpful for resolution by the Employee Relations Administrator.
6. Supervisors may be required to take immediate action to maintain a safe environment and will not be required to undertake any further implementation of the Employee Performance and Conduct Policy and/or will not be required to contact the Employee Relations Administrator. In the event of serious misconduct by an employee, employment may be suspended, with or without pay, or the employee may be or immediately terminated.

Examples of serious offenses include, but are not limited to:

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<td>Fighting</td>
<td>Failing to comply with licensing or certification requirements</td>
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<td>Insubordination</td>
<td>Misuse of University credit card</td>
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<td>Timesheet violations</td>
<td>Reporting to work/working while under the influence or possession of intoxicants</td>
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<td>Falsifying University records</td>
<td>Job abandonment</td>
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<td>Sleeping on duty</td>
<td>Possession of a weapon</td>
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7. Creighton University reserves the right to administer appropriate disciplinary action for all forms of inappropriate performance and/or conduct. No list of rules can include all instances of conduct resulting in disciplinary action. Sound judgment and common sense prevail.

**ADMINISTRATION AND INTERPRETATION**

Questions regarding this policy should be directed to the Human Resources Department.

**AMENDMENTS OR TERMINATION OF THIS POLICY**

Creighton University reserves the right to modify, amend, or terminate this policy at any time.
Policies and Procedures

SECTION:  
Administration

CHAPTER:  
Human Resources

POLICY:  
Pre-Employment Background Investigations

PURPOSE

The purpose of this policy is to provide the University with an additional tool for identifying candidates who will contribute to the health, safety and wellbeing of our students, patients, visitors, faculty and staff, as well as the overall University environment. In addition, it will further assure compliance with state and federal laws.

SCOPE

This policy applies to all full- and part-time staff positions. All newly hired staff employees (external candidates) and current employees applying for a new position (internal candidates) will be subject to a background investigation. It should not be assumed that a thorough investigation was completed when a staff employee was originally hired or that information revealed in a previous background investigation has not changed. In addition, if adverse information is reported for a current Creighton staff employee (internal candidate) it may adversely impact his/her current employment.

POLICY

Background investigations will be conducted, via a contractual arrangement with an outside vendor once an official offer of employment has been extended. The actual commencement of employment will be contingent upon the results of the screening process.

Confidentiality: The handling of all records and subject information will be strictly confidential and revealed only to those required to have access. Any breach of confidentiality will be considered serious and appropriate disciplinary action will be taken.

The Human Resources Department will determine the investigations to be conducted based upon duties and responsibilities, autonomy levels, and amount of supervision provided the position. Investigations will include, but not be limited to, a combination of the following screenings:

- County Criminal Record Search (Required)
- Social Security Number Search (Required)
- Alias Name Search (Required)
- Found Protection Orders (Required)
- Found Wants and Warrants (Required)
- Residential History Search (Required)
- Office of the Inspector General (OIG)
- Cumulative Sanction Report (Required for all employees involved in Health Care.)
- Federal Criminal Record Search
- Credit Report
- Driving Record
- Education and/or License Verification
- Employment or Personal Reference Check
- Sex Offender Registry
**Policies and Procedures**

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**PROCEDURES**

During the candidate interview process, the hiring supervisor will:

- Secure a completed Background Investigation Acknowledgement and Authorization form, (a sample copy of this form is attached to this policy). Each interviewed candidate must complete and sign Section I of the Background Investigation Acknowledgement and Authorization form.
- Provide each candidate with a copy of the Background Investigation Acknowledgement and Authorization form, which describes the requested investigation(s).

When an offer of employment has been extended to a candidate, the hiring supervisor will:

- Verbally obtain the information to complete Section II of the Background Investigation Acknowledgement and Authorization form.
- Forward the completed Background Investigation Acknowledgement and Authorization form to the appropriate Human Resources representative for processing.

Employment will be conditional upon receipt of results.

**Outcome of Background Investigation:**

If the results indicate suitability for employment, a Human Resource representative will notify the hiring supervisor that the candidate may be contacted to coordinate a start date.

If the results indicate any adverse information:

A conviction for a felony or misdemeanor, *by itself, does not disqualify a candidate from employment.* Consideration will be given to:

- the number of convictions;
- the nature, seriousness and date(s) of occurrence of the violation(s);
- rehabilitation;
- relevance of crime committed in relation to position;
- state or federal requirements related to the position; and
- other evidence demonstrating an ability to perform the job competently and free from posing a threat to the health and safety of others.

The Employment/Recruitment staff and the Director of Human Resources will review the results of the background investigation in relation to the position under consideration. All known factors regarding the candidate will be considered. If the decision requires additional review, the Director of Human Resources will consult with the area Vice President and the General Counsel’s Office (if necessary).
A) If a favorable decision is made to continue with the hiring process, a Human Resource representative will notify the hiring supervisor to proceed. The results of a background check will only be shared with a hiring supervisor if the Director of Human Resources determines it is necessary.

B) If it is determined that the applicant is ineligible for the position, the Human Resources Department will notify the hiring supervisor that the hiring decision is "on hold" pending notification of the candidate regarding the results.

The Notification Process:
A Human Resources representative will notify the candidate via an Adverse Letter of Notification, informing him/her of the results of the background check (a sample copy of this letter is attached to this policy). According to the Fair Credit Reporting Act, the Human Resources Department will provide a copy of the report only if employment is denied based on the results of the background investigation. The Adverse Letter of Notification will also include instructions for contesting this information in accord with the procedures of the vendor.

The Human Resources Department will provide the candidate with:

♦ A copy of the Background Check
♦ A copy of Your Rights Under the Fair Credit Reporting Act
♦ A copy of the name and telephone number of the vendor

Disputing the Background Check report:
A) A candidate is allowed seven business days from the date on the Adverse Letter of Notification, to contact a Human Resources representative to discuss what information in the report caused ineligibility for hire. AND

B) The candidate must contact the vendor directly within seven business days from the date on the Adverse Letter of Notification. (Failure to complete steps A and B will result in automatic disqualification from the hiring process.)

C) The vendor is required to investigate the disputed information within ten business days from the date on the complaint.

Until a final decision is made, the individual will not be allowed to begin employment and the position will not be filled by another candidate.
Once the reinvestigation of disputed information has been completed:

The ultimate determination regarding the candidate’s suitability for employment will be made by the applicable Vice President, in consultation with the Director of Human Resources, and based upon final background investigation results.

It will be at the discretion of the applicable Vice President and the Human Resources Director to determine if any background check results will be disseminated to the hiring supervisor.

**Note:** The outside vendor conducting the background investigation is not responsible for the decision to hire or not hire. Once a final decision is made, a Human Resources representative will notify the candidate.

Any identified misrepresentation, falsification, or material omission of information from the employment application/resume discovered during the selection process or after hire, may exclude the candidate (external or internal) from consideration for the position, or result in withdrawal of an offer of employment, or immediate termination.

Creighton University reserves the right to conduct a background investigation when an employee is charged with any crime that reflects on his/her suitability for continued employment. Background investigations may also be initiated as a result of an internal administrative investigation.

**ADMINISTRATION AND INTERPRETATIONS**

Questions about this policy can be directed to the Director of Human Resources. In addition, the General Counsel’s Office and Compliance Officer for the Health Sciences Schools may also be a helpful resource.

**AMENDMENTS OR TERMINATION OF THIS POLICY**

Creighton University reserves the right to modify, amend, or terminate this policy at any time.
Background Investigation Acknowledgement and Authorization

In connection with my application for employment, I understand that a background investigation will be conducted which will include, but may not be limited to, a combination of the following screenings:

- County Criminal Record Search (Required)
- Federal Criminal Record Search (Required)
- Alias Name Search (Required)
- Credit Report
- Found Wants and Warrants (Required)
- Driving Record
- Found Protection Orders (Required)
- Education and/or License Verification
- Residential History Search (Required)
- Employment or Personal Reference Check
- Social Security Number Search (Required)
- Sex Offender Registry
- Office of the Inspector General (OIG) Cumulative Sanction Report (Required for all employees involved in Health Care)

My signature below indicates I have received a copy of this form and I authorize Creighton University to conduct the required background investigation used in connection with consideration of my application for employment. I release Creighton University and its partners, officers, directors, agents, employees, affiliates, and its agent Vendor from any and all liability for any damages which may arise from or relate to any consumer report and/or investigative consumer report and/or other background investigation requested, obtained or used by Creighton University with my application for employment. Special note to internal candidates (current employees): The result of this investigation may adversely impact your current employment with the University.

Section I (Candidate): (Please Print)

Name: ____________________________

Last          First          Middle

Other Names Used: __________________________

Current Address: __________________________

Street          City          State          Zip Code

Prior Address: __________________________

Street          City          State          Zip Code

I understand that if adverse information is revealed, I will be notified in writing by the Human Resources Department. I will have seven business days, from the date on the written notice, to contact the Human Resources Department to discuss the adverse information. I further understand that I must also notify Vendor to contest the results of the background check within seven business days from the date of the written notice to me. Failure to complete any part of this process in described time frames will automatically result in disqualification from the hiring process.

Signature: ____________________________ Date: ____________

Section II (Final Candidate): (To be completed by Hiring Supervisor)

Date of Birth (Month, Day, Year) __________________________ Gender __________________________ Social Security Number __________________________

Driver’s License Number and State of Issuance  (Only if position requires driving record check)
Adverse Letter Sample

**** DRAFT ****

Name
Address
City, State, Zip

Dear :

As authorized in the employment application process, Creighton University contracted with Vendor to complete a pre-employment background investigation. The purpose of this letter is to inform you that there is information in the results of the report which, if accurate, would prevent us from offering you employment at this time. A copy of the report is enclosed.

If, after reviewing the report, you believe the information in the report is inaccurate and/or you want to know what information in the report made you ineligible for hire, please contact me directly within seven business days from the date of this letter at (402)280-xxxx. If you do not respond, it will be assumed that you no longer wish to pursue employment with Creighton University.

Also enclosed is a description of your rights under the Fair Credit Reporting Act (F.C.R.A.). It is important to note that although Vendor is not responsible for the decision to hire or not hire, according to the law, you have the right to dispute any information in this report directly with the Vendor. You are responsible for providing notification to Vendor if the information reported to Creighton University is believed to be inaccurate or incomplete within seven business days from the date on this notice. Vendor is then required to re-verify the information within ten business days from the date on your complaint. If the information is found to be inaccurate, incomplete, or cannot be verified; Vendor will promptly modify the report and notify Creighton’s Human Resources representatives.

To contact Vendor, you may write or call:

Vendor
P.O. Box 1234
Omaha, NE 00000
(402) 000-0000

Sincerely,

HR Representative
Human Resources Department
Creighton University

Enclosure: Background Report
Policies and Procedures

SECTION: Administration

CHAPTER: Human Resources

POLICY:
Prohibition of Weapons and Concealed Handguns

PURPOSE
Effective January 1, 2007, Nebraska residents may obtain a permit to carry a concealed handgun. A property owner may prohibit persons from carrying concealed handguns and other weapons on its property.

Creighton University is committed to providing a safe environment for its students, faculty and staff and all visitors to the campus.

POLICY
All faculty, staff, students and all other persons are prohibited from carrying a weapon of any kind, including concealed handguns, onto Creighton property or into any Creighton facility.

This prohibition includes concealed handguns that are legally carried under state law.

EXCEPTION
The only exceptions to this policy are on-duty Public Safety officers and on-duty law enforcement personnel, who are permitted to carry weapons on University property.

SCOPE
All faculty, staff, students and all other persons are covered by this policy.

An employee who violates this policy will be asked to remove the weapon from campus immediately and will be subject to disciplinary action, up to and including termination of employment. Further, Creighton may contact the appropriate law enforcement agency if it learns that an employee has violated or is violating the policy. The employee may also be subject to arrest.

If an employee believes that a co-worker has brought a weapon or a concealed handgun onto the premises or intends to do so, the employee should alert Public Safety and Human Resources.
A student who violates this policy will be asked to remove the weapon from campus immediately and will be subject to disciplinary action pursuant to the Student Handbook. Further, Creighton may contact the appropriate law enforcement agency if it learns that a student has violated or is violating the policy. The student may also be subject to arrest.

If a student believes that a fellow student has brought a weapon or a concealed handgun onto the premises or intends to do so, the student should alert Public Safety and Student Services.

A person other than an employee or student who violates this policy will be asked to remove the weapon from campus immediately. Further, Creighton may contact the appropriate law enforcement agency if it learns that such person has violated or is violating the policy. Such person may also be subject to arrest.

Questions about this policy should be directed to Public Safety.

DEFINITIONS

A handgun means any firearm with a barrel less than 16 inches in length or any firearm designed to be held and fired by the use of a single hand. A concealed handgun means a handgun that is totally hidden from view.

A weapon is defined as any object or substance designed to inflict a wound, cause injury or incapacitate, including all firearms, BB, potato and pellet guns, knives with blades three and one-half inches or more in length, or any other device, instrument, material or substance, whether animate or inanimate, which in the manner it is used or intended to be used is capable of producing death or serious bodily injury.

NOTICES

The Creighton community will be informed about Creighton’s stand on concealed handguns and weapons though the publication of the policy addressed above.

Creighton will post notices stating that concealed handguns, as well as other weapons, are not allowed on the Creighton campus.

Signs will be posted on the entrances to selected parking lots and parking garages, the entrance to the periphery road (Wareham Parkway) and other key public and visitor entrances to campus. Off-campus leased and owned facilities will also have signs.
PURPOSE

The purpose of this policy is to provide general guidelines regarding the use of a flexible work schedule. Flexible work arrangements allow employees to complete their employment duties and responsibilities while working a non-traditional work schedule. A flexible work arrangement can be a useful method to meet both the department’s operational requirements and support an employee’s personal needs. Although a flexible work schedule does not apply to all employees or all types of positions, it can result in improved morale, increased productivity and decreased absenteeism.

POLICY

The first priority of each University department is to accomplish its objectives. Therefore, the use of flexible work schedules should not decrease a department’s productivity nor adversely affect another department’s operations, services provided to the University, its constituents and the general public. Examples of a flexible work schedule include, but are not limited to:

- Non-traditional start and end-time (e.g., working 9:00 a.m. to 6:00 p.m. or 7:00 a.m. to 4:00 p.m.)
- Longer workdays and shorter workweeks (e.g., 4, 10-hour days)
- Extended mid-day/lunch hours offset by additional hours worked at the beginning or end of the shift (e.g., working 7:00 a.m. to 11:00 a.m. and 2:00 p.m. to 6:00 p.m.)

SCOPE

This policy applies to all benefit-eligible staff employees.

ELIGIBILITY

Not all employees’ positions are suitable for a flexible work schedule arrangement. Final approval of a flexible work schedule will be made by the applicable department head in consultation with the Human Resources Department.

ADMINISTRATION AND INTERPRETATIONS

Specific questions regarding flexible work schedules should be directed to the Human Resources Department.

AMENDMENTS OR TERMINATION OF THIS POLICY

Creighton University reserves the right to modify, amend or terminate this policy at any time, especially in order to comply with changes in federal and state law.
PURPOSE

The purpose of this policy is to communicate Creighton University’s position of zero tolerance for any form of retaliation against any employee, student or University contractor who makes a good faith report of financial misconduct by any means. The University is committed to high ethical standards in financial practices and believes that the good faith reporting of suspected or known financial misconduct is the responsibility of all employees, students and contractors with whom the University does business.

DEFINITIONS

Contractor – any individual, partnership, corporation or other business entity outside of Creighton University with whom the University conducts business.
Employee – any present or past University faculty or staff member, including all full-time, part-time, temporary, and student employees.
Financial misconduct – (see Policy 3.1.16., Reporting Financial Misconduct)
Good faith reporting – any reporting based upon factual information that would lead a reasonable person to believe that financial misconduct has occurred, is occurring or will occur.
Retaliation – taking, failing to take, or threatening to take any action against an employee, student or contractor because the individual makes a good faith report of suspected financial misconduct or participates, in good faith, in an investigation of suspected financial misconduct.
Student – any current or past student enrolled at Creighton University.

POLICY /PROCEDURES

Any verified instance of retaliation against a student, employee or contractor related to a good faith report of financial misconduct will result in disciplinary action against the responsible party, up to and including potential termination of contract, enrollment or employment.

SCOPE

This policy applies to all students, faculty, staff and contractors with whom the University conducts business. Due to the University’s size and diverse locations, it is the responsibility of management and supervisors across the University to enforce this policy. Any person who believes he or she has been retaliated against, in violation of this policy, may also contact Human Resources (for staff employees), the Faculty Grievance Committee (for faculty members), the Purchasing Director (for contractors) or the Associate Vice President for Student Services (for students).

AMENDMENTS AND TERMINATION OF THIS POLICY

The University reserves the right to modify, amend or terminate this policy at any time.
**Policies and Procedures**

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| POLICY: Job Posting and Transfer Process | PAGE 1 OF 3 |

**PURPOSE**

The objective of the policy is to ensure that all employees are made aware of and have the opportunity to apply for open positions either before or concurrent with the University’s consideration of external candidates for employment. The policy provides guidelines regarding the transfer and promotion of Creighton University staff employees.

**POLICY**

Creighton University is committed to providing career development and growth opportunities for employees which benefit both the individual and the organization. On occasion, special circumstances may arise that could cause a position to be filled without posting. The circumstances include, but are not limited to: executive positions, organizational restructuring and position elimination. The decision not to post a staff position will be made by the Human Resources Director or designee. Selection decisions will be based on job related factors such as skills, experience, education, training and work history.

**SCOPE**

This policy applies to all benefit-eligible employees, excluding faculty.

**JOB POSTING**

Job openings will be posted on the Creighton Human Resources Career website at [https://careers.creighton.edu](https://careers.creighton.edu) for a minimum of five (5) days and the job posting will include the job title, department, job summary, essential duties and minimum qualifications.

**ELIGIBILITY**

Employees are eligible to apply for another position after six (6) months in his/her position. This six-month requirement may be waived with agreement of both the releasing manager and receiving manager and is subject to Human Resources Director or designee review and approval.

Employees who have a corrective action on file in Human Resources within the past six (6) months are not eligible to apply for a transfer or promotion.
DEFINITIONS

Transfer is the movement of an employee from one position to another position at the same grade level.
Promotion is the movement of an employee from one position to another position in a higher grade level.

PROCEDURES

1. Employee

The employee is responsible for evaluating his/her own career interests and goals and completing an online application through the Human Resources website. The employee is encouraged to notify his/her supervisor that he/she is applying for a position. If the employee chooses not to notify his/her supervisor, the hiring manager will contact the releasing manager/supervisor only if the employee is considered a serious candidate.

2. Hiring Manager

The hiring manager is responsible for filling the position with the most qualified candidate without regard to age, color, race, national origin, religion, gender, disability or veteran status. Prior to making an offer, the hiring manager will contact the releasing manager to verify performance, skills and attendance.

3. Releasing Manager

The releasing manager should understand and encourage employees’ career goals, assist in defining career objectives and encourage employees to pursue career development. They should also provide accurate and factual feedback to the hiring manager and Human Resources regarding the internal applicant’s job performance.

The releasing manager and hiring manager should collaborate to determine the employee’s transfer date. The releasing manager should update the employee’s performance evaluation.
4. Human Resources

Human Resources will review each applicant’s qualifications and will actively participate in the screening and interview process in collaboration with the hiring manager.

The Human Resources Department reviews the employee’s personnel file, reviews performance information, extends the offer and completes pre-employment requirements such as an applicable background check.

Pay Changes

All changes in pay will be consistent with the University’s compensation guidelines. The salary offered for the new position will be determined on the employee’s qualifications for the new position and internal equity within the department or work group.

ADMINISTRATION AND INTERPRETATIONS

Specific questions regarding internal transfer procedures should be directed to the Human Resources Department.

AMENDMENTS OR TERMINATION OF THIS POLICY

Creighton University reserves the right to modify, amend or terminate this policy at any time, especially in order to comply with changes in federal and state law.
PURPOSE

The purpose of this policy is to provide paid parental leave to benefit-eligible University employees. Parental leave will provide parents with additional flexibility and time to bond with a new child, adjust to their new family situation, and provide increased balance to their employment and family obligations.

ELIGIBILITY

To be eligible for parental leave, the employee must have been employed by the University in a benefit-eligible status during the entire 12-month period immediately prior to the birth or adoption of a child. In the case where both parents are Creighton employees, both are eligible for this leave.

POLICY

The provisions of this policy are:

1. To provide 4 weeks of paid leave for the birth or adoptive parent(s).
2. Eligible employees may only use paid parental leave during the first 12 weeks following the birth or adoption of a child. For adoptive parents the leave may begin at the time the employee travels to a destination to obtain the adoptive child.
3. If the employee is eligible for Family and Medical Leave (FMLA), paid parental leave will run concurrently (please refer to University policy 2.2.14 regarding FMLA).
4. Supervisors, Deans, or Department Chairs are required to work with eligible faculty and staff to redistribute duties, including teaching responsibilities, during the 12-week entitlement period.

SCOPE

This policy applies to all benefit-eligible employees (faculty and staff).

ADMINISTRATION AND INTERPRETATION

Questions regarding this policy should be directed to the Associate Vice President of Human Resources.

AMENDMENT OR TERMINATION OF THIS POLICY

Creighton University reserves the right to modify, amend or terminate this policy at any time.
## Purpose

To define procedures for requesting new construction or renovation/remodeling projects.

## Policy

Requests for all facility work shall be forwarded to the University Plant Office. If an outside Architect/Engineer is required for a project they shall be retained by the University Plant Office. No design, construction, or repair for Creighton University shall be initiated by anyone other than University Plant personnel.

## Procedure

1. Forward a written request to the University Plant Office. Provide as much information as possible. Plant personnel may require a meeting or on-site visit.

2. A Project Endorsement Form with a preliminary estimate will be prepared by the University Plant Office. The Project Endorsement Form will be provided to the requesting department for use in obtaining approval.

3. When an approved Endorsement Form is received by the Plant, the work will be scheduled in coordination with the requestor.
PURPOSE

The purpose of an Energy Conservation Program is to establish recognition and understanding of energy saving policies and techniques used by the University on a day-to-day basis.

The objectives of this Energy Conservation Program are to:

- Establish guidelines for the proper management of our energy resources: domestic water, steam, chilled water and electricity.
- Control the waste of natural resources.
- Maintain the most comfortable and safest environmental conditions in University buildings at the lowest cost.
- Provide education to faculty, staff, and students in the day-to-day practice of energy conservation.

POLICY

The following are temperature set points for different space needs:

<table>
<thead>
<tr>
<th></th>
<th>SUMMER</th>
<th>WINTER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office Space:</td>
<td>74°F</td>
<td>70°F</td>
</tr>
<tr>
<td>Classrooms:</td>
<td>74°F</td>
<td>68°F</td>
</tr>
<tr>
<td>Living Quarters</td>
<td>74°F</td>
<td>70°F</td>
</tr>
<tr>
<td>Laboratories</td>
<td>74°F</td>
<td>68°F</td>
</tr>
</tbody>
</table>

Exceptions:

Facilities Management is aware that there are areas in some of the buildings that require special consideration with regard to heating, air conditioning, humidification and dehumidification. These needs will be addressed on a case-by-case basis. Further, in the event of humidity control during the summer, it may be more economical to lower cooling temperatures in lieu of using a heat source to warm the dry air up to the temperature set point.

To request an exception, complete the Temperature Change Request Form and send it to the Superintendent of Operations, Facilities Management, for review. The review will be completed in ten (10) working days and a response will be provided to the individual submitting the request.
### SCOPE

**METHODS OF ENERGY CONSERVATION**

Energy conservation is the responsibility of all employees of the University.

Practices to be implemented by faculty, staff, and students:

- Turn off all lighting in unoccupied areas (even for brief periods).
- Turn off office machines and computers when leaving an office unoccupied for more than an hour.
- Do not prop open doors leading to the outside of buildings. Open doors and windows in the winter can cause freeze-ups in radiators near windows and result in broken water pipes.
- Building occupants are encouraged to participate in Energy Siesta.
- Do not open windows during the heating season. Note: Open windows and doors send erroneous information to the thermostats causing excess energy use.
- Electric space heaters use a lot of electricity as well as being a fire hazard. If an area is cold, notify Facilities Management of the intent to buy a space heater so efforts to identify and correct the problem can be exhausted. Only Facilities Management approved and issued space heaters are to be used.
- All University departments are required to submit a yearly occupancy schedule for their area.
- Report any obvious malfunctions or abuses of energy on the campus to Facilities Management.

Practices to be implemented by Facilities Management:

- Manage the day-to-day operations of the University’s buildings and grounds.
- Maintain and repair all University HVAC equipment.
- Maintain a close watch on the development of new technologies industry-wide to help the campus achieve the best possible results. Promote and participate in conservation programs developed and coordinated by the Energy Awareness Committee.
- Comply with procedures for the purchase and installation of lab equipment that meets reasonable energy usage requirement. The Purchasing Department will review requests for new appliances with Facilities Management identifying the impact of the purchase on the building or space environments.
### Policies and Procedures

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<th>SECTION: Administration</th>
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<td>CHAPTER: Facilities</td>
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<td>7/18/94</td>
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<td>10/18/05</td>
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<tr>
<td>POLICY: Energy Conservation</td>
<td>PAGE 3 OF 3</td>
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- Promote and celebrate Earth Day annually through activities by the Energy Awareness Committee and other groups.
- Comply with code and regulations which dictate methods and means of energy conservation.
- Develop and implement load shedding opportunities to shut down equipment to reduce peak demand of energy.
- Encourage use of renewable energy consumption such as solar power and wind power.
- Design all new buildings and space remodel projects with products and systems that minimize energy consumption. Examples include, use of motion detectors for light switches and use of window covering as an insulator or a means of passive solar heat gain.
- Encourage substantial reduction of heating temperatures and cooling temperatures during times when the University is closed for business. Individuals who work outside of the normal office hours may be subjected to uncomfortable temperatures as a result of the reduction.
- Maintain the appropriate space temperature for all building areas.
- Accomplish preventive maintenance designed to insure that all University energy consuming equipment operates efficiently and within its capability.
- Operate a computerized energy management system to insure the most economical use of heating and cooling equipment while also maintaining reasonable environmental conditions.
Temperature Change Request Form

Name: ___________________________ Phone: ___________________________
Department: ___________________________ E-mail: ___________________________
Room #: ___________________________

Temperature Set Points:

<table>
<thead>
<tr>
<th></th>
<th>Summer</th>
<th>Winter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office space</td>
<td>74°</td>
<td>70°</td>
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</tr>
<tr>
<td>Laboratories</td>
<td>74°</td>
<td>68°</td>
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</table>

Please complete all information.

1. The temperature requested other than listed above: ____________.

2. Is this due to a medical condition? Yes _____ No _____
   If yes, please provide a letter from your physician.

3. If this request is due to special equipment needs (lab, computer, etc.) or any other reason unrelated to a medical condition, please provide a clear and concise explanation of the need in the space below. Include any available manufacturer’s literature or other supporting documents with your submission.

This request must be approved by your department chair and either your Dean or Vice President.

_____________________________  _________________
Dept. Chair                  Date

_____________________________  _________________
Dean/Vice President          Date

Forward to Facilities Management with all documentation. Failure to obtain the appropriate signatures or submit a complete application will delay the review.
Policies and Procedures

SECTION: Administration
NO. 2.4.1.

CHAPTER: Information Technology

ISSUED: 4/7/06
REV. A
REV. B

POLICY: Risk Analysis Policy

PURPOSE

The purpose of this policy is to comply with the Health Insurance Portability and Accountability Act (HIPAA) Security Rule’s requirements pertaining to the integrity, confidentiality, and availability of electronic protected health information (ePHI).

SCOPE

This policy covers all electronic protected health information (ePHI), which is a person’s identifiable health information. This policy covers all ePHI, which is available currently, or which may be created, used in the future. This policy applies to all faculty, staff, students, residents, postdoctoral fellows, and non-employees (including visiting faculty, courtesy, affiliate, and adjunct faculty, industrial personnel, and others) who collect, maintain, use, or transmit ePHI in connection with activities at Creighton University.

POLICY

Creighton University requires systems administrators of systems that store, access, transmit, manipulate, input, or output Protected Health Information conduct a regular, accurate, and thorough assessment of the risks and vulnerabilities to the confidentiality, integrity, and availability of ePHI. An assessment must be conducted before a new system goes into production or as material changes are made to existing systems.

DEFINITIONS

Protected Health Information
Individually identifiable health information transmitted or maintained in any form.

Electronic Protected Health Information (ePHI)
Individually identifiable health information transmitted or maintained in electronic form.

RESPONSIBILITIES

Systems Administrators are responsible for adhering to this policy.

ADMINISTRATION AND INTERPRETATIONS

This policy shall be administered by Information Security. Questions regarding this policy should be directed to the Information Security Officer.
## Policies and Procedures

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### AMENDMENT/TERMINATION OF THIS POLICY

The University reserves the right to modify, amend or terminate this policy at any time. This policy does not constitute a contract between the University and its faculty or employees.

### REFERENCES TO APPLICABLE POLICIES


### EXCEPTIONS

None

### VIOLATIONS/ENFORCEMENT

Any known violations of this policy should be reported to the University's Information Security Officer at 402-280-2386 or via e-mail to infosec@creighton.edu.

Violations of this policy can result in immediate withdrawal or suspension of system and network privileges and/or disciplinary action in accordance with University procedures.

The University may advise law enforcement agencies when a criminal offense may have been committed.
Policies and Procedures

SECTION: Administration

CHAPTER: Information Technology

POLICY: Risk Management Policy

PURPOSE

The purpose of this policy is to ensure that Creighton University is properly addressing the risks inherent in operating and maintaining information systems required for continued operations.

SCOPE

This policy covers all data and information systems owned, operated, leased, or in the care of Creighton University as well as those who utilize them.

POLICY

Creighton University must conduct a regular, accurate, and thorough assessment of the risks and vulnerabilities to its information systems and electronic resources. Security controls must be implemented for each system to reduce risks and vulnerabilities to a reasonable and appropriate level. Creighton University must also regularly evaluate these measures and safeguards to ensure their effectiveness.

Any new system must have a risk assessment performed prior to it promotion into production environments.

DEFINITIONS

Electronic Resources – All computer related equipment, computer systems, software, networks, facsimile machines, voicemail and other telecommunications facilities, as well as all information or data contained therein.

Device Managers – Entity responsible for maintaining or managing a class of information systems.

Security Controls - Mechanism, either technical or procedural, designed to reduce risk.

RESPONSIBILITIES

Information Security Office is responsible for development of a risk management program and for conducting risk analysis of University systems.

Device Managers are responsible for assisting the Information Security Office in the performance of the risk analysis and for implementing security measures and safeguards identified to mitigate risk.
Vice President for Information Technology is responsible for setting and defining the acceptable levels of risk for University systems.

Change Advisory Board will review all new systems to ensure an initial Risk Assessment has been conducted prior to moving new systems into production.

**ADMINISTRATION AND INTERPRETATIONS**

This policy shall be administered by Information Security. Questions regarding this policy should be directed to the Information Security Officer.

**AMENDMENT/TERMINATION OF THIS POLICY**

The University reserves the right to modify, amend or terminate this policy at any time. This policy does not constitute a contract between the University and its faculty or employees.

**REFERENCES TO APPLICABLE POLICIES**

- Risk Management Program
- Change Advisory Board Operating Procedures

**EXCEPTIONS**

None

**VIOLATIONS/ENFORCEMENT**

Any known violations of this policy should be reported to the University's Information Security Officer at 402-280-2386 or via e-mail to infosec@creighton.edu.

Violations of this policy can result in immediate withdrawal or suspension of system and network privileges and/or disciplinary action in accordance with University procedures.

The University may advise law enforcement agencies when a criminal offense may have been committed.
# Sanction Policy

**PURPOSE**

The purpose of this policy is to outline Creighton University’s procedures as it pertains to non-compliance with University’s information technology policies.

**SCOPE**

This policy applies to all faculty, staff, students, residents, postdoctoral fellows, and non-employees (including visiting faculty, courtesy, affiliate, and adjunct faculty, industrial personnel, and others) who collect, maintain, use, or transmit Creighton’s data in connection with activities at Creighton University (CU).

**POLICY**

Creighton University will appropriately discipline employees and other workforce members for any violation of information technology policy or procedure to a degree appropriate for the gravity of the violation. These sanctions include, but are not limited to, re-training, verbal and written warnings and other disciplinary action in accordance with University procedures.

In addition, workforce members who knowingly and willfully violate state or federal law for improper use or disclosure of an individual’s information are subject to criminal investigation and prosecution or civil monetary penalties.

Creighton University will investigate any security incidents or violations and mitigate to the extent possible any negative effects that the incident may have had in a timely manner.

Creighton University and its workforce members will not intimidate or retaliate against any workforce member or individual that reports the incident.

**DEFINITIONS**

- **Creighton Data**
  Any data owned or entrusted to Creighton University.

- **Security Incident**
  Any adverse event that affects the confidentiality, integrity, or availability of data or systems.
**Policies and Procedures**

**SECTION:** Administration  
**NO.:** 2.4.3.

**CHAPTER:** Information Technology  
**ISSUED:** 4/7/06  
**REV. A:** 3/14/12  
**REV. B:**

**POLICY:** Sanction Policy  
**PAGE 2 OF 3**

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**Workforce Member**
Any faculty, staff, students, residents, postdoctoral fellows, and non-employees (including visiting faculty, courtesy, affiliate, and adjunct faculty, industrial personnel, and others) who collect, maintain, use, or transmit Creighton’s data in connection with activities at Creighton University.

**Sensitive Data**
Data generated by or entrusted to Creighton University which meets the definitions of Confidential or Private data as defined by the Data Classification Policy of Creighton University.

**RESPONSIBILITIES**

All individuals identified in the scope of this policy are responsible for compliance with any sanction that is applied to them under this policy.

**Information Security Office** is responsible for reviewing reported security incidents and violations of security policy and levying, based on the gravity of the breach, appropriate sanctions upon the workforce member.

**ADMINISTRATION AND INTERPRETATIONS**
This policy shall be administered by Information Security. Questions regarding this policy should be directed to the Information Security Officer.

**AMENDMENT/TERMINATION OF THIS POLICY**

The University reserves the right to modify, amend or terminate this policy at any time. This policy does not constitute a contract between the University and its faculty or employees.

**REFERENCES TO APPLICABLE POLICIES**

- Data Classification Policy

**EXCEPTIONS**

None
**Policies and Procedures**

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</table>

**VIOLATIONS/ENFORCEMENT**

Any known violations of this policy should be reported to the University's Information Security Officer at 402-280-2386 or via e-mail to infosec@creighton.edu.

Violations of this policy can result in immediate withdrawal or suspension of system and network privileges and/or disciplinary action in accordance with University procedures.

The University may advise law enforcement agencies when a criminal offense may have been committed.
PURPOSE

The purpose of this policy is to establish a requirement to enable and review logs on Creighton IT resources that store, access or transmit data classified by Creighton as Confidential or Private.

SCOPE

This policy covers all Creighton data which is available currently, or which may be created, used in the future. This policy applies to all individuals who maintain affected systems or data.

POLICY

IT resources that store, access or transmit data classified, by Creighton University, as Confidential or Private shall be electronically logged. Logging shall include system, application, database and file activity whenever available or deemed necessary.

- Logging shall include creation, access, modification and deletion activities.
- Log files shall be regularly examined for access control discrepancies, breaches, and policy violations.
- Data custodians or device managers are responsible for developing appropriate processes for monitoring and analyzing their logs.
- Individuals shall not be assigned to be the sole reviewers of their own user activity.
- System activity review cycles shall include review of audit logs minimally every 30 days and may include daily exception reporting.

DEFINITIONS

Confidential Data
A class of data whereby its unauthorized disclosure, alteration or destruction could result in significant risk to the mission, safety or integrity of the University and/or its constituents.

Private Data
A class of data whereby its unauthorized disclosure, alteration or destruction could result in moderate risk to the mission, safety or integrity of the University and/or its constituents.

Device Managers
Entity responsible for maintaining or managing a class of information systems.
**Data Custodian**
Those who are authorized by the Data Owner to use or manipulate data. Data Custodians have the responsibility to adhere to all policies applicable to the data entrusted to them.

**RESPONSIBILITIES**

**Data Owners** are responsible for assigning the classifications categories to their data, and have the primary responsibility for ensuring the appropriate use and security of the data.

**Date Custodians** are responsible for identifying the systems that must be reviewed based on the classification assigned by the data owners, the information on these systems that must be reviewed, the types of access reports that are to be generated, and the individual(s) responsible for reviewing all logs and reports. The data custodians are also responsible for ensuring appropriate evidence of regular log review is happening in accordance with this policy.

**Information Security Office** is responsible for verifying that a review process has been implemented in an effective manner.

**ADMINISTRATION AND INTERPRETATIONS**

This policy shall be administered by Information Security. Questions regarding this policy should be directed to the Information Security Officer.

**AMENDMENT/TERMINATION OF THIS POLICY**

The University reserves the right to modify, amend or terminate this policy at any time. This policy does not constitute a contract between the University and its faculty or employees.

**REFERENCES TO APPLICABLE POLICIES**

Data Classification Policy

**EXCEPTIONS**

None
VIOLATIONS/ENFORCEMENT

Any known violations of this policy should be reported to the University's Information Security Officer at 402-280-2386 or via e-mail to infosec@creighton.edu.

Violations of this policy can result in immediate withdrawal or suspension of system and network privileges and/or disciplinary action in accordance with University procedures.

The University may advise law enforcement agencies when a criminal offense may have been committed.
**Policies and Procedures**

**SECTION:** Administration  
**NO.:** 2.4.5.

**CHAPTER:** Information Technology  
**ISSUED:** 4/7/06  
**REV. A**  
**REV. B**

**POLICY:** Authorization Policy  
**PAGE 1 OF 3**

**PURPOSE**

The purpose of this policy is to comply with the Health Insurance Portability and Accountability Act (HIPAA) Security Rule’s requirements pertaining to the integrity, confidentiality, and availability of electronic protected health information (ePHI).

**SCOPE**

This policy covers all electronic protected health information (ePHI), which is a person’s identifiable health information. This policy covers all ePHI, which is available currently, or which may be created, used in the future. This policy applies to all faculty, staff, students, residents, postdoctoral fellows, and non-employees (including visiting faculty, courtesy, affiliate, and adjunct faculty, industrial personnel and others) who collect, maintain, use, or transmit ePHI in connection with activities at Creighton University.

**POLICY**

Creighton University requires the implementation of security safeguards to ensure that all members of the workforce who have access to ePHI, including operations and maintenance employees:

- Need the access they have
- Have the access they need
- Understand the limits of access to ePHI
- Understand how to authenticate themselves to the system or application

**DEFINITIONS**

**Protected Health Information**
Individually identifiable health information transmitted or maintained in any form.

**Electronic Protected Health Information (ePHI)**
Individually identifiable health information transmitted or maintained in electronic form.

**Security Safeguards**
Documented processes or procedures designed to reduce risk.
WORKFORCE MEMBER
Any Staff, Faculty, Student, or designated 3rd party resource that works with ePHI

RESPONSIBILITIES

SYSTEMS ADMINISTRATORS are responsible for developing and implementing written security safeguards to ensure electronic access to ePHI is properly granted.

Information Security Office is responsible for ensuring all systems that collect, maintain, use or transmit ePHI have security safeguards implemented to regulate electronic access.

Network users are responsible for adhering to the standards outlined in this policy when using Creighton University’s computers or network.

ADMINISTRATION AND INTERPRETATIONS

This policy shall be administered by Information Security. Questions regarding this policy should be directed to the Information Security Officer.

AMENDMENT/TERMINATION OF THIS POLICY

The University reserves the right to modify, amend or terminate this policy at any time. This policy does not constitute a contract between the University and its faculty or employees.

REFERENCES TO APPLICABLE POLICIES


EXCEPTIONS

None
## Policies and Procedures

| SECTION: Administration | NO. | 2.4.5. |
|--------------------------|-----|--|---|
| CHAPTER: Information Technology | ISSUED: | 4/7/06 | REV. A | REV. B |
| POLICY: Authorization Policy | | | |
| VIOLATIONS/ENFORCEMENT | |

Any known violations of this policy should be reported to the University's Information Security Officer at 402-280-2386 or via e-mail to infosec@creighton.edu.

Violations of this policy can result in immediate withdrawal or suspension of system and network privileges and/or disciplinary action in accordance with University procedures.

The University may advise law enforcement agencies when a criminal offense may have been committed.
PURPOSE

The purpose of this policy is to comply with the Health Insurance Portability and Accountability Act (HIPAA) Security Rule’s requirements pertaining to the integrity, confidentiality, and availability of electronic protected health information (ePHI).

SCOPE

This policy covers all electronic protected health information (ePHI), which is a person’s identifiable health information. This policy covers all ePHI, which is available currently, or which may be created, used in the future. This policy applies to all faculty, staff, students, residents, postdoctoral fellows, and non-employees (including visiting faculty, courtesy, affiliate, and adjunct faculty, industrial personnel and others) who collect, maintain, use, or transmit ePHI in connection with activities at Creighton University.

POLICY

Creighton University requires the development and implementation of procedures to ensure that the ePHI access of its workforce members is appropriate when granted and continues to be appropriate on an on-going basis. Creighton requires documentation detailing each Workforce member's current role and responsibilities and the ePHI access required for such role and responsibilities.

DEFINITIONS

Protected Health Information
Individually identifiable health information transmitted or maintained in any form.

Electronic Protected Health Information (ePHI)
Individually identifiable health information transmitted or maintained in electronic form.

Workforce Member
Any Staff, Faculty, Student, or designated 3rd party resource that works with ePHI
# Workforce Clearance Policy

## RESPONSIBILITIES

- **Systems Administrators or their designee** is required to develop and implement written procedures to adhere to this policy.

- **Information Security Officer** is responsible for periodic verification that such processes or procedures have been implemented for each system that collects, maintains, uses or transmits ePHI.

## ADMINISTRATION AND INTERPRETATIONS

This policy shall be administered by Information Security. Questions regarding this policy should be directed to the Information Security Officer.

## AMENDMENT/TERMINATION OF THIS POLICY

The University reserves the right to modify, amend or terminate this policy at any time. This policy does not constitute a contract between the University and its faculty or employees.

## REFERENCES TO APPLICABLE POLICIES


## EXCEPTIONS

None

## VIOLATIONS/ENFORCEMENT

Any known violations of this policy should be reported to the University's Information Security Officer at 402-280-2386 or via e-mail to infosec@creighton.edu.

Violations of this policy can result in immediate withdrawal or suspension of system and network privileges and/or disciplinary action in accordance with University procedures.

The University may advise law enforcement agencies when a criminal offense may have been committed.
### PURPOSE

The purpose of this policy is to comply with the Health Insurance Portability and Accountability Act (HIPAA) Security Rule’s requirements pertaining to the integrity, confidentiality, and availability of electronic protected health information (ePHI).

### SCOPE

This policy covers all electronic protected health information (ePHI), which is a person’s identifiable health information. This policy covers all ePHI, which is available currently, or which may be created, used in the future. This policy applies to all faculty, staff, students, residents, postdoctoral fellows, and non-employees (including visiting faculty, courtesy, affiliate, and adjunct faculty, industrial personnel, and others) who collect, maintain, use, or transmit ePHI in connection with activities at Creighton University.

### POLICY

If a workforce member’s employment is terminated or a workforce member leaves the University, the workforce member’s supervisor or manager must immediately notify Human Resources and ensure that all system or application accounts with access to EPHI are terminated.

### DEFINITIONS

**Workforce Member**
Any Staff, Faculty, Student, or designated 3rd party resource that works with ePHI

**Supervisor / Manager**
Person responsible for directing the work assignments of a workforce member.

### RESPONSIBILITIES

**Workforce Supervisors / Managers** are responsible for ensuring that Human Resources and System/Application Administrators are notified when a workforce member is terminated or leaves the University.

**Systems Administrator** is responsible for removing, in a timely manner, access for any person who no longer has a need to access such information.
ADMINISTRATION AND INTERPRETATIONS

This policy shall be administered by Information Security. Questions regarding this policy should be directed to the Information Security Officer.

AMENDMENT/TERMINATION OF THIS POLICY

The University reserves the right to modify, amend or terminate this policy at any time. This policy does not constitute a contract between the University and its faculty or employees.

REFERENCES TO APPLICABLE POLICIES


EXCEPTIONS

None

VIOLATIONS/ENFORCEMENT

Any known violations of this policy should be reported to the University's Information Security Officer at 402-280-2386 or via e-mail to infosec@creighton.edu.

Violations of this policy can result in immediate withdrawal or suspension of system and network privileges and/or disciplinary action in accordance with University procedures.

The University may advise law enforcement agencies when a criminal offense may have been committed.
Policies and Procedures

SECTION: Administration

CHAPTER: Information Technology

POLICY: Access Authorization Policy

PURPOSE

The purpose of this policy is to comply with the Health Insurance Portability and Accountability Act (HIPAA) Security Rule’s requirements pertaining to the integrity, confidentiality, and availability of electronic protected health information (ePHI).

SCOPE

This policy covers all electronic protected health information (ePHI), which is a person’s identifiable health information. This policy covers all ePHI, which is available currently, or which may be created, used in the future. This policy applies to all faculty, staff, students, residents, postdoctoral fellows, and non-employees (including visiting faculty, courtesy, affiliate, and adjunct faculty, industrial personnel, and others) who collect, maintain, use, or transmit ePHI in connection with activities at Creighton University.

POLICY

System Administrators who are responsible for systems that collect, maintain, use or transmit ePHI will grant access to system users following a formal request made by the supervisor of the specific user and/or data owner. Access to the system(s) will be limited to specific, defined, documented and approved applications and levels of access rights.

DEFINITIONS

Protected Health Information (PHI)
Individually identifiable health information transmitted or maintained in any form.

Electronic Protected Health Information (ePHI)
Individually identifiable health information transmitted or maintained in electronic form.

Data Owner
The individual responsible for the policy and practice decisions of data.

RESPONSIBILITIES

System Users are responsible for adhering to the standards outlined in this policy when using Creighton University’s Systems that contain e-PHI.

System Administrators are responsible for granting the appropriate access to users requesting access and for requiring authorization from supervisors/data owners before granting access.
Supervisors are responsible for requesting access from the appropriate system administrator for the users that they supervise.

Information Security Officer is responsible for verifying that the established access authorization controls are sufficient for each system and application that maintains ePHI and that the process has been implemented in an effective manner.

ADMINISTRATION AND INTERPRETATIONS

This policy shall be administered by Information Security. Questions regarding this policy should be directed to the Information Security Officer.

AMENDMENT/TERMINATION OF THIS POLICY

The University reserves the right to modify, amend or terminate this policy at any time. This policy does not constitute a contract between the University and its faculty or employees.

REFERENCES TO APPLICABLE POLICIES


EXCEPTIONS

None

VIOLATIONS/ENFORCEMENT

Any known violations of this policy should be reported to the University's Information Security Officer at 402-280-2386 or via e-mail to infosec@creighton.edu.

Violations of this policy can result in immediate withdrawal or suspension of system and network privileges and/or disciplinary action in accordance with University procedures.

The University may advise law enforcement agencies when a criminal offense may have been committed.
Policies and Procedures

SECTION: Administration

CHAPTER: Information Technology

POLICY: Access Establishment Policy

PURPOSE

The purpose of this policy is to comply with the Health Insurance Portability and Accountability Act (HIPAA) Security Rule’s requirements pertaining to the integrity, confidentiality, and availability of electronic protected health information (ePHI).

SCOPE

This policy covers all electronic protected health information (ePHI), which is a person’s identifiable health information. This policy covers all ePHI, which is available currently, or which may be created, used in the future. This policy applies to all faculty, staff, students, residents, postdoctoral fellows, and non-employees (including visiting faculty, courtesy, affiliate, and adjunct faculty, industrial personnel, and others) who collect, maintain, use, or transmit ePHI in connection with activities at Creighton University.

POLICY

Creighton University requires the creation and maintenance of access control related capabilities to ensure that access is limited to approved rights.

A regular review shall be conducted to ensure that access rights for each individual or entity are consistent with established policies and job roles and functions.

Access control related capabilities shall be utilized to ensure that status changes such as termination or change in job role are reflected in rights granted to individuals or entities.

DEFINITIONS

Protected Health Information (PHI)
Individually identifiable health information transmitted or maintained in any form.

Electronic Protected Health Information (ePHI)
Individually identifiable health information transmitted or maintained in electronic form.

Access control related capabilities
Documented manual or technical procedures for determining that access rights granted to individuals with access to ePHI remain relevant and accurate.
RESPONSIBILITIES

**System Users** are responsible for adhering to the standards outlined in this policy when using Creighton University’s Systems that contain e-PHI.

**System Administrators** are responsible for granting the appropriate access to users requesting access and for requiring authorization from supervisors before granting access. Systems administrators are also responsible for conducting periodic reviews to ensure that access rights for each individual or entity are consistent with established policies and job roles and functions.

**Supervisors** are responsible for requesting access from the appropriate system administrator for the users that they supervise.

**Information Security Officer** is responsible for verifying that access controls are sufficient for each system and application that maintains ePHI and that a review process has been implemented in an effective manner.

ADMINISTRATION AND INTERPRETATIONS

This policy shall be administered by Information Security. Questions regarding this policy should be directed to the Information Security Officer.

AMENDMENT/TERMINATION OF THIS POLICY

The University reserves the right to modify, amend or terminate this policy at any time. This policy does not constitute a contract between the University and its faculty or employees.

REFERENCES TO APPLICABLE POLICIES


EXCEPTIONS

None
VIOLATIONS/ENFORCEMENT

Any known violations of this policy should be reported to the University's Information Security Officer at 402-280-2386 or via e-mail to infosec@creighton.edu.

Violations of this policy can result in immediate withdrawal or suspension of system and network privileges and/or disciplinary action in accordance with University procedures.

The University may advise law enforcement agencies when a criminal offense may have been committed.
# Policies and Procedures

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<td>REV. A</td>
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## PURPOSE

The purpose of this policy is to comply with the Health Insurance Portability and Accountability Act (HIPAA) Security Rule’s requirements pertaining to the integrity, confidentiality, and availability of electronic protected health information (ePHI).

## SCOPE

This policy covers all electronic protected health information (ePHI), which is a person’s identifiable health information. This policy covers all ePHI, which is available currently, or which may be created, used in the future. This policy applies to all faculty, staff, students, residents, postdoctoral fellows, and non-employees (including visiting faculty, courtesy, affiliate, and adjunct faculty, industrial personnel, and others) who collect, maintain, use, or transmit ePHI in connection with activities at Creighton University.

## POLICY

Creighton University will provide HIPAA training to all individuals who access protected health information. Training will be conducted regularly and will include regular security reminders regarding changes to Creighton security policies, new vulnerabilities and viruses, and new or updated federal regulations.

## DEFINITIONS

**Protected Health Information**
Individually identifiable health information transmitted or maintained in any form.

**Electronic Protected Health Information (ePHI)**
Individually identifiable health information transmitted or maintained in electronic form.

## RESPONSIBILITIES

**Information Security Officer** is responsible for the development of training material and reminders.

**Department Administrators** are responsible for ensuring all employees, students, staff, faculty, etc. who have access to protected health information are notified and attend or pass HIPAA training.
**Policies and Procedures**

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**ADMINISTRATION AND INTERPRETATIONS**

This policy shall be administered by Information Security. Questions regarding this policy should be directed to the Information Security Officer.

**AMENDMENT/TERMINATION OF THIS POLICY**

The University reserves the right to modify, amend or terminate this policy at any time. This policy does not constitute a contract between the University and its faculty or employees.

**REFERENCES TO APPLICABLE POLICIES**


**EXCEPTIONS**

None

**VIOLATIONS/ENFORCEMENT**

Any known violations of this policy should be reported to the University's Information Security Officer at 402-280-2386 or via e-mail to infosec@creighton.edu.

Violations of this policy can result in immediate withdrawal or suspension of system and network privileges and/or disciplinary action in accordance with University procedures.

The University may advise law enforcement agencies when a criminal offense may have been committed.
**Policies and Procedures**

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<td>POLICY: Data Classification Policy</td>
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**PURPOSE**

The purpose of this policy is to ensure the appropriate level of protection is applied to University data and enable those who handle data to be able to easily make decisions when managing the data.

**SCOPE**

This policy applies to all data generated, accessed, modified, transmitted, stored, or used by the University, irrespective of the medium on which the data resides (paper, hard drive, CD/DVD, etc.), or the format of the data (text, graphics, video, voice, etc.).

All University faculty, staff, agents, and contractors must abide by the required security controls defined for each classification level.

**POLICY**

All University data must be classified into one of three sensitivity levels by the appropriate Data Owner: Confidential, Private, or Public. A document, file, or information system is classified according to the most sensitive level of data contained therein and should be labeled in accordance with the **Data Labeling Standard**.

A. **Confidential (High Sensitivity)**
   Data should be classified as Confidential if its unauthorized disclosure could result in significant legal, financial, reputational, or other adverse impact upon the University, due to legal or regulatory requirements, University policies or agreements to which the University is a party, or because of the sensitivity of the information. Examples of Confidential data can be found in Appendix A.

B. **Private (Medium Sensitivity)**
   Data should be classified as Private when the unauthorized disclosure, alteration or destruction of that data could result in harm to the University’s image or reputation, or could undermine the confidentiality of University business or processes, but would not necessarily violate existing federal or local laws, University policies, or University contracts. Data in this category are not routinely distributed outside the University, and distributed within the University on a need-to-know basis. Examples of Private data can be found in Appendix A.

C. **Public (Low Sensitivity)**
   Data should be classified as Public when the unauthorized disclosure, alteration or destruction of that data would result in little or no risk to the University and its affiliates. Public data has no legal or other restrictions on access or usage and may be open to the University community and the general public. Examples of Public data can be found in Appendix A.
DEFINITIONS

Data Owners – Those who generate data or those to whom data are entrusted. Data owners assign the classification categories to their data, and have the primary responsibility for ensuring the appropriate use and security of the data. “Data Owners” is used as a term of art for the purpose of this and related University policies, and does not refer to the actual legal ownership of particular data.

RESPONSIBILITIES

Data Owners are responsible for classifying data under this policy.

ADMINISTRATION AND INTERPRETATIONS

This policy shall be administered by Information Security. Questions regarding this policy should be directed to the Information Security Officer.

AMENDMENT/TERMINATION OF THIS POLICY

The University reserves the right to modify, amend or terminate this policy at any time. This policy does not constitute a contract between the University and its faculty or employees.

REFERENCES TO APPLICABLE POLICIES

Data Handling Policy
Data Labeling Standard
Data Destruction Standard
Data Stewardship Policy

EXCEPTIONS

None
VIOLATIONS/ENFORCEMENT

Any known violations of this policy should be reported to the University's Information Security Officer at 402-280-2386 or via e-mail to infosec@creighton.edu.

Violations of this policy can result in immediate withdrawal or suspension of system and network privileges and/or disciplinary action in accordance with University procedures.

The University may advise law enforcement agencies when a criminal offense may have been committed.
<table>
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<th><strong>APPENDIX A</strong></th>
<th><strong>DATA CLASSIFICATION SNAPSHOT</strong></th>
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<tr>
<td><strong>Confidential</strong></td>
<td><strong>Private</strong></td>
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<td>(High Sensitivity)</td>
<td>(Medium Sensitivity)</td>
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**Description**
- Data which is legally regulated; and data that would provide access to Confidential or Private data.
- Data which the Data Owners have not decided to publish or make public; and data protected by certain contractual obligations.
- Data for which there is no expectation for privacy or confidentiality.

**Legal Requirements**
- Protection of data is required by law or contract.
- Protection of data required by contract.
- None. Protection of data is at the discretion of the Data Owner or Data Custodian.

**Reputational Risk**
- High
- Medium
- Low

**Data Access and Control**
- Legal, ethical, or other constraints prevent access without specific authorization. Data is accessible only to those individuals designated with approved access and signed non-disclosure agreements.
- University privacy, ethical, and reputational concerns prevent access without specific authorization. Data is accessible only to those individuals designated with approved access and signed non-disclosure agreements.
- No access restrictions. Data is available for public access.

**Transmission**
- Transmission of Confidential data through any non-Creighton network is prohibited (e.g. Internet). Transmission through any electronic messaging system (e-mail, instant messaging, text messaging) is also prohibited.
- Transmission of Private data through any non-Creighton network is strongly discouraged. Third party email services are not appropriate for transmitting Private data.
- No encryption or other protection is required for public data; however, care should always be taken to use all University data appropriately.

**Storage**
- Storage of Confidential data is prohibited on Individual-Use Electronic Devices and media unless approved by the Information Security Officer. If approved, additional protective measures, including encryption will be required.
- Level of required protection of Private data is either pursuant to Creighton policy or at the discretion of the owner or custodian of the data. If appropriate level of protection is not known, check with Information Security Officer before storing Private data unencrypted.
- No encryption or other protection is required for public data; however, care should always be taken to use all University data appropriately.

**Documented Backup and Recovery Procedures**
- Documented backup and recovery procedures are required.
- Documented backup and recovery procedures are not necessary, but strongly encouraged.
- Documented Backup and Recovery Procedures are not necessary, but strongly encouraged.

**Audit Controls**
- Data Owner and Data Custodians with responsibility for Confidential data must actively monitor and review their systems and procedures for potential misuse and/or unauthorized access.
- Data Owners and Data Custodians with responsibility for Private data must periodically monitor and review their systems and procedures for potential misuse and/or unauthorized access.
- No audit controls are required.

**Examples**
- Information resources with access to Confidential data (username and password).
  - Student Data not included in directory information. This includes:
    - Loan or scholarship information
    - Payment history
    - Student tuition bills
    - Student financial aid information
    - Class lists or enrollment information
    - Transcripts; grade reports
    - Notes on class work
    - Disciplinary action
    - Athletics or department recruiting
  - Personal/Employee Data
    - Payroll information
    - Personnel records, performance reviews, benefit information
    - Race, ethnicity, and/or nationality
    - Gender
    - Date and place of birth
  - Business/Financial Data
    - Financial transactions which do not include confidential data
    - Information covered by non-disclosure agreements
    - Contracts – that don’t contain PII
    - Credit reports
    - Assets/Net Worth
    - Records on spending and
  - Certain directory/contact information not designated by the owner as Private.
    - Name
    - Addresses (campus and home)
    - Email address
    - Listed telephone number(s)
    - Degrees, honors and awards
    - Major field of study
    - Dates of current employment,
<table>
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<tr>
<th>Information</th>
<th>Borrowing</th>
<th>Position(s)</th>
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| Personally Identifiable Information (PII): Last name, and first name or initial, with any one of following:  | **Academic / Research Information**  
• Library transactions (e.g., catalog, circulation, acquisitions)  
• Unpublished research or research details or results that are not regulated or considered confidential data  
• Non-anonymous faculty course evaluations  
• Private funding information  
**Anonymous Donor Information**  
Last name, first name or initial (and/or name of organization if applicable) with any of the following:  
• Gift information, including amount and purpose of commitment  
**Other Donor Information**  
Last name, first name or initial (and/or name of organization if applicable) with any of the following:  
• Telephone/fax numbers  
• E-Mail, URLs  
• Employment information  
• Family information (spouse(s)/partner/guardian/children/grandchildren, etc.)  
**Management Data**  
Detailed annual budget information  
Conflict of Interest Disclosures  
University’s investment information  
**Systems/Log Data**  
Server Event Logs  
**Research Data**  
Research data that is private but not protected by law.  |
|                      | **Specific for students:**  
• Class year  
• Participation in campus activities and sports  
• Weight and height (athletics)  
• Dates of attendance  
• Status  |
|                      | **Business Data**  
• Campus maps  
• Job postings  
• List of publications (published research)  |
Policies and Procedures

SECTION: Administration

CHAPTER: Information Technology

POLICY: Log-in Monitoring Policy

PURPOSE

The purpose of this policy is to comply with the Health Insurance Portability and Accountability Act (HIPAA) Security Rule’s requirements pertaining to the integrity, confidentiality, and availability of electronic protected health information (ePHI).

SCOPE

This policy covers all electronic protected health information (ePHI), which is a person’s identifiable health information. This policy covers all ePHI, which is available currently, or which may be created, used in the future. This policy applies to all faculty, staff, students, residents, postdoctoral fellows, and non-employees (including visiting faculty, courtesy, affiliate, and adjunct faculty, industrial personnel, and others) who collect, maintain, use, or transmit ePHI in connection with activities at Creighton University.

POLICY

To ensure that access to servers, workstations, and other computer systems containing PHI is appropriately secured; Creighton University will configure all critical components that process, store or transmit ePHI to record log-in attempts – both successful and unsuccessful – as well as automatic lock out and reporting after 3 failed attempts.

DEFINITIONS

Protected Health Information
Individually identifiable health information transmitted or maintained in any form.

Electronic Protected Health Information (ePHI)
Individually identifiable health information transmitted or maintained in electronic form.

Log-in Monitoring
The process of logging or recording all successful and unsuccessful log-in attempts in order to monitor or hacking or other inappropriate activity.

Automatic Lock Out
The process of locking an account after a predetermined number of unsuccessful login attempts.
RESPONSIBILITIES

Network users are responsible for understanding and consenting to Creighton University's use of tools and processes to monitor system activity.

Administrators of systems that maintain PHI are responsible for ensuring the policies statements detailed above are implemented on all systems that store, transmit, or maintain PHI.

ADMINISTRATION AND INTERPRETATIONS

This policy shall be administered by Information Security. Questions regarding this policy should be directed to the Information Security Officer.

AMENDMENT/TERMINATION OF THIS POLICY

The University reserves the right to modify, amend or terminate this policy at any time. This policy does not constitute a contract between the University and its faculty or employees.

REFERENCES TO APPLICABLE POLICIES


EXCEPTIONS

None

VIOLATIONS/ENFORCEMENT

Any known violations of this policy should be reported to the University's Information Security Officer at 402-280-2386 or via e-mail to infosec@creighton.edu.

Violations of this policy can result in immediate withdrawal or suspension of system and network privileges and/or disciplinary action in accordance with University procedures.

The University may advise law enforcement agencies when a criminal offense may have been committed.
PURPOSE

To ensure that passwords are handled in a secure manner and to provide assurance that they are a trusted factor for authentication to access University assets.

SCOPE

This policy applies to all individuals who are granted an electronic identity at Creighton University or systems that store or process electronic identities.

POLICY

Passwords are the minimum factor that can be used for authenticating an individual and tying him or her to an electronic identity for the purpose of accessing information systems at Creighton. As they are often the primary and sole factor in ensuring accurate identity information, they must be treated as Confidential data as outlined in the Data Classification Policy and the Data Handling Policy. Specifically, passwords:

- MUST be changed at least every 180 days.
- MUST meet the following complexity requirements, when technically possible:
  - Be at least 8 characters in length
  - Contain at least 3 of 4 types of characters
    - Uppercase Latin letters [A-Z]
    - Lowercase Latin letters [a-z]
    - Digits [0-9]
    - Non-alphanumeric printable characters (e.g.: !@#$%^&)
  - MUST NOT contain any significant portion of the username/NetID
  - MUST NOT contain any part of an individual’s first or last name.
- MUST not be shared with any individual at any time for any purpose.
  - The only exception is one time use passwords or passwords with a limited lifetime for the purposes of activating or establishing an account.
- MUST NOT be written down or stored in any manner that would allow them to be viewed by other individuals.

DEFINITIONS

System Administrator - An individual responsible for maintaining an information technology system.

System User - An individual who has been granted an account to access any Creighton system.
RESPONSIBILITIES

System Administrators are responsible for ensuring, where possible, that password parameters on systems they administer meet a minimum level of complexity, length, and age.

System Users are responsible for safeguarding their passwords.

Information Security Office is responsible for validating that all systems adhere to this policy.

ADMINISTRATION AND INTERPRETATIONS

This policy shall be administered by Information Security. Questions regarding this policy should be directed to the Information Security Officer.

AMENDMENT/TERMINATION OF THIS POLICY

The University reserves the right to modify, amend or terminate this policy at any time. This policy does not constitute a contract between the University and its faculty or employees.

REFERENCES TO APPLICABLE POLICIES

Classification Policy
Data Handling Policy

EXCEPTIONS

Exceptions to this policy must be approved by the Information Security Office.

VIOLATIONS/ENFORCEMENT

Any known violations of this policy should be reported to the University's Information Security Officer at 402-280-2386 or via e-mail to infosec@creighton.edu.

Violations of this policy can result in immediate withdrawal or suspension of system and network privileges and/or disciplinary action in accordance with University procedures.

The University may advise law enforcement agencies when a criminal offense may have been committed.
PURPOSE

The purpose of this policy is to outline how Creighton handles Information security incidents in order to ensure the confidentiality, integrity, and availability of Creighton data.

SCOPE

This policy applies to all individuals or organizations that collect, maintain, use, or transmit Creighton data.

POLICY

All incidents that affect or may affect the confidentiality, integrity, or availability of Creighton data must be reported in accordance to the procedures defined in Creighton’s Incident Response Plan.

DEFINITIONS

Security Incident is any adverse event that threatens the confidentiality, integrity, or availability of Creighton University information assets, information systems, networks, or data entrusted to Creighton University. A violation or imminent threat of violation of information security policies, acceptable use policies, or security practices is an incident. Examples include but are not limited to: lost or stolen devices, shared passwords, unauthorized disclosure of protected data, virus infections, etc.

RESPONSIBILITIES

Information Security Office is responsible for administration of Creighton’s Incident Response Plan.

AMENDMENT/TERMINATION OF THIS POLICY

The University reserves the right to modify, amend or terminate this policy at any time. This policy does not constitute a contract between the University and its faculty or employees.

REFERENCES TO APPLICABLE POLICIES

None

EXCEPTIONS

None
VIOLATIONS/ENFORCEMENT

Any known violations of this policy should be reported to the University's Information Security Officer at 402-280-2386 or via e-mail to infosec@creighton.edu.

Violations of this policy can result in immediate withdrawal or suspension of system and network privileges and/or disciplinary action in accordance with University procedures.

The University may advise law enforcement agencies when a criminal offense may have been committed.
**Policies and Procedures**

**SECTION:** Administration  
**CHAPTER:** Information Technology  
**POLICY:** Data Backup Policy  
**ISSUED:** 4/7/06  
**REV. A**  
**REV. B**  
**NO.** 2.4.15.

**PURPOSE**

The purpose of this policy is to comply with the Health Insurance Portability and Accountability Act (HIPAA) Security Rule’s requirements pertaining to its response to an emergency or other occurrence that damages systems that contain electronic protected health information (ePHI).


**SCOPE**

The scope of this Policy contains procedures regarding a contingency plan that shall be developed and implemented in the event of an emergency, disaster or other occurrence (i.e. fire, vandalism, system failure and natural disaster) when any system that contains electronic protected health information (ePHI) is affected, including data backup, disaster recovery planning and emergency mode operation plan. This policy covers all electronic protected health information (ePHI), which is a person’s identifiable health information. This policy covers all ePHI, which is available currently, or which may be created, used in the future. This policy applies to all faculty, staff, students, residents, postdoctoral fellows, and non-employees (including visiting faculty, courtesy, affiliate, and adjunct faculty, industrial personnel, and others) who collect, maintain, use, or transmit ePHI in connection with activities at Creighton University.

**POLICY**

Creighton University requires each system that collects, maintains, uses or transmits ePHI have a documented data backup plan to create, maintain, and recover exact copies of all ePHI.

The Data Backup Plan must require that all media used for backing up ePHI be stored physically in a secure environment, such as a protected, off-site storage facility. If an off-site storage facility or backup service is used, a written contract or agreement must be used to ensure that the vendor will safeguard the ePHI in an appropriate manner. If backup media remains on-site, it must be stored physically in a secure location other than the location of the backed up computer systems.

Data backup procedures detailed in the Data Backup Plan must be tested on a periodic basis to ensure that exact copies of ePHI can be recovered and made available.
DEFINITIONS

Protected Health Information
Individually identifiable health information transmitted or maintained in any form.

Electronic Protected Health Information (ePHI)
Individually identifiable health information transmitted or maintained in electronic form.

RESPONSIBILITIES

Network administrators are responsible for adhering to the standards outlined in this policy when administering Creighton University’s computers or network.

ADMINISTRATION AND INTERPRETATIONS

This policy shall be administered by Information Security. Questions regarding this policy should be directed to the Information Security Officer.

AMENDMENT/TERMINATION OF THIS POLICY

The University reserves the right to modify, amend or terminate this policy at any time. This policy does not constitute a contract between the University and its faculty or employees.

REFERENCES TO APPLICABLE POLICIES


EXCEPTIONS

None
<table>
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<th>POLICY:</th>
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<tr>
<td>Data Backup Policy</td>
</tr>
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**VIOLATIONS/ENFORCEMENT**

Any known violations of this policy should be reported to the University's Information Security Officer at 402-280-2386 or via e-mail to infosec@creighton.edu.

Violations of this policy can result in immediate withdrawal or suspension of system and network privileges and/or disciplinary action in accordance with University procedures.

The University may advise law enforcement agencies when a criminal offense may have been committed.
**Policies and Procedures**

**SECTION:** Administration  
**CHAPTER:** Information Technology  
**POLICY:** Disaster Recovery Policy  
**NO.** 2.4.16.  
**ISSUED:** 4/7/06  
**REV. A**  
**REV. B**

**PURPOSE**

The purpose of this policy is to comply with the Health Insurance Portability and Accountability Act (HIPAA) Security Rule’s requirements pertaining to its response to an emergency or other occurrence that damages systems that contain electronic protected health information (ePHI).

**SCOPE**

The scope of this policy contains procedures regarding a contingency plan that shall be developed and implemented in the event of an emergency, disaster or other occurrence (i.e. fire, vandalism, system failure and natural disaster) when any system that contains electronic protected health information (ePHI) is affected, including data backup, disaster recovery planning and emergency mode operation plan. This policy covers all electronic protected health information (ePHI), which is a person’s identifiable health information. This policy covers all ePHI, which is available currently, or which may be created, used in the future. This policy applies to all faculty, staff, students, residents, postdoctoral fellows, and non-employees (including visiting faculty, courtesy, affiliate, and adjunct faculty, industrial personnel, and others) who collect, maintain, use, or transmit ePHI in connection with activities at Creighton University.

**POLICY**

Creighton University requires each system that collects, maintains, uses or transmits ePHI have a documented disaster recovery plan developed and implemented to ensure recoverability from the loss of data due to an emergency or disaster such as fire, vandalism, terrorism, system failure, or natural disaster.

The Disaster Recovery Plan must include procedures to restore or recover any loss of ePHI due to an emergency or disaster from data backups and the systems needed to make that ePHI available in a timely manner.

The Disaster Recovery Plan must include procedures to log system outages, failures, and data loss to critical systems, and procedures to train the appropriate personnel to implement the disaster recovery plan.

The Disaster Recovery Plan must be documented and easily available to the necessary trained personnel at all time to implement the Disaster Recovery Plan.

**DEFINITIONS**

**Protected Health Information**  
Individually identifiable health information transmitted or maintained in any form.
Electronic Protected Health Information (ePHI)
Individually identifiable health information transmitted or maintained in electronic form.

Disaster Recovery Plan
A documented process for recovering from a system outage in an organized and repeatable manner.

RESPONSIBILITIES

Network administrators are responsible for the creation, maintenance, and implementation of the disaster recovery plan for each system that collects, maintains, uses or transmits ePHI.

Information Security Officer is responsible for ensuring each system that collects, maintains, uses or transmits ePHI has a documented disaster recovery plan that is tested periodically.

ADMINISTRATION AND INTERPRETATIONS

This policy shall be administered by Information Security. Questions regarding this policy should be directed to the Information Security Officer.

AMENDMENT/TERMINATION OF THIS POLICY

The University reserves the right to modify, amend or terminate this policy at any time. This policy does not constitute a contract between the University and its faculty or employees.

REFERENCES TO APPLICABLE POLICIES


EXCEPTIONS

None
### VIOLATIONS/ENFORCEMENT

Any known violations of this policy should be reported to the University's Information Security Officer at 402-280-2386 or via e-mail to infosec@creighton.edu.

Violations of this policy can result in immediate withdrawal or suspension of system and network privileges and/or disciplinary action in accordance with University procedures.

The University may advise law enforcement agencies when a criminal offense may have been committed.
PURPOSE

The purpose of this policy is to comply with the Health Insurance Portability and Accountability Act (HIPAA) Security Rule’s requirements pertaining to its response to an emergency or other occurrence that damages systems that contain electronic protected health information (ePHI).

SCOPE

The scope of this Policy contains procedures regarding a contingency plan that shall be developed and implemented in the event of an emergency, disaster or other occurrence (i.e. fire, vandalism, system failure and natural disaster) when any system that contains electronic protected health information (ePHI) is affected, including data backup, disaster recovery planning and emergency mode operation plan. This policy covers all electronic protected health information (ePHI), which is a person’s identifiable health information. This policy covers all ePHI, which is available currently, or which may be created, used in the future. This policy applies to all faculty, staff, students, residents, postdoctoral fellows, and non-employees (including visiting faculty, courtesy, affiliate, and adjunct faculty, industrial personnel, and others) who collect, maintain, use, or transmit ePHI in connection with activities at Creighton University.

POLICY

Creighton University requires that an Emergency Mode Operation Plan be developed and implemented to enable continuation of critical business processes and to protect the security of ePHI while operating in emergency mode.

Emergency mode operation procedures detailed in the Emergency Mode Operation Plan must be tested on a periodic basis to ensure that critical business processes can continue in a satisfactory manner while operating in emergency mode.

DEFINITIONS

Protected Health Information
Individually identifiable health information transmitted or maintained in any form.

Electronic Protected Health Information (ePHI)
Individually identifiable health information transmitted or maintained in electronic form.
## Policies and Procedures

<table>
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<tr>
<th>SECTION: Administration</th>
<th>NO.</th>
<th>2.4.17.</th>
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<tr>
<td>CHAPTER: Information Technology</td>
<td>ISSUED:</td>
<td>REVS. A</td>
</tr>
<tr>
<td>Emergency Mode Of Operation Policy</td>
<td>4/7/06</td>
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</tr>
</tbody>
</table>

### Emergency Mode of Operation Plan
Procedures to enable continuation of critical business processes for protection of the security of ePHI while operating in an emergency mode.

### RESPONSIBILITIES

- **Network administrators** are responsible for the creation, maintenance, and implementation of the disaster recovery plan for each system that collects, maintains, uses or transmits ePHI.

- **Information Security Officer** is responsible for ensuring each system that collects, maintains, uses or transmits ePHI has a documented disaster recovery plan that is tested periodically.

### ADMINISTRATION AND INTERPRETATIONS

This policy shall be administered by Information Security. Questions regarding this policy should be directed to the Information Security Officer.

### AMENDMENT/TERRMINATION OF THIS POLICY

The University reserves the right to modify, amend or terminate this policy at any time. This policy does not constitute a contract between the University and its faculty or employees.

### REFERENCES TO APPLICABLE POLICIES


### EXCEPTIONS

None
VIOLATIONS/ENFORCEMENT

Any known violations of this policy should be reported to the University's Information Security Officer at 402-280-2386 or via e-mail to infosec@creighton.edu.

Violations of this policy can result in immediate withdrawal or suspension of system and network privileges and/or disciplinary action in accordance with University procedures.

The University may advise law enforcement agencies when a criminal offense may have been committed.
PURPOSE

The purpose of this policy is to comply with the Health Insurance Portability and Accountability Act (HIPAA) Security Rule’s requirements pertaining to its response to an emergency or other occurrence that damages systems that contain electronic protected health information (ePHI).

SCOPE

The scope of this Policy contains procedures regarding a contingency plan that shall be developed and implemented in the event of an emergency, disaster or other occurrence (i.e. fire, vandalism, system failure and natural disaster) when any system that contains electronic protected health information (ePHI) is affected, including data backup, disaster recovery planning and emergency mode operation plan. This policy covers all electronic protected health information (ePHI), which is a person’s identifiable health information. This policy covers all ePHI, which is available currently, or which may be created, used in the future. This policy applies to all faculty, staff, students, residents, postdoctoral fellows, and non-employees (including visiting faculty, courtesy, affiliate, and adjunct faculty, industrial personnel, and others) who collect, maintain, use, or transmit ePHI in connection with activities at Creighton University.

POLICY

Creighton University requires testing procedures be developed for the data backup, disaster recovery, and emergency mode operations plan. These plans must be tested on a periodic basis to ensure that critical business processes can continue in a satisfactory manner, with or without the availability of the primary delivery method. Revisions to plans described based on changes due to systems design, policy changes (internal or external), or testing results will be documented and submitted.

DEFINITIONS

Protected Health Information
Individually identifiable health information transmitted or maintained in any form.

Electronic Protected Health Information (ePHI)
Individually identifiable health information transmitted or maintained in electronic form.

Data Backup Plan
A documented process for ensuring the security and reliability of data backups.
Disaster Recovery Plan
A documented process for recovering from a system outage in an organized and repeatable manner.

Emergency Mode of Operation Plan
Procedures to enable continuation of critical business processes for protection of the security of ePHI while operating in an emergency mode.

RESPONSIBILITIES

Network administrators are responsible for the creation, maintenance, and implementation of the testing and revision plan for each system that collects, maintains, uses, or transmits ePHI.

Information Security Officer is responsible for ensuring each system that collects, maintains, uses or transmits ePHI has a documented testing and revision plan.

ADMINISTRATION AND INTERPRETATIONS

This policy shall be administered by Information Security. Questions regarding this policy should be directed to the Information Security Officer.

AMENDMENT/TERMINATION OF THIS POLICY

The University reserves the right to modify, amend or terminate this policy at any time. This policy does not constitute a contract between the University and its faculty or employees.

REFERENCES TO APPLICABLE POLICIES


EXCEPTIONS

None
VIOLATIONS/ENFORCEMENT

Any known violations of this policy should be reported to the University's Information Security Officer at 402-280-2386 or via e-mail to infosec@creighton.edu.

Violations of this policy can result in immediate withdrawal or suspension of system and network privileges and/or disciplinary action in accordance with University procedures.

The University may advise law enforcement agencies when a criminal offense may have been committed.
Policies and Procedures

SECTION: Administration

CHAPTER: Information Technology

POLICY: Evaluation Policy

PURPOSE

The purpose of this policy is to comply with the Health Insurance Portability and Accountability Act (HIPAA) Security Rule’s requirements pertaining to the integrity, confidentiality, and availability of electronic protected health information (ePHI).

SCOPE

This policy covers all electronic protected health information (ePHI), which is a person’s identifiable health information. This policy covers all ePHI, which is available currently, or which may be created, used in the future. This policy applies to all faculty, staff, students, residents, postdoctoral fellows, and non-employees (including visiting faculty, courtesy, affiliate, and adjunct faculty, industrial personnel and others) who collect, maintain, use, or transmit ePHI in connection with activities at Creighton University.

POLICY

Creighton University will evaluate the technical and non-technical implementations of its Security Policies and procedures. This evaluation will be completed on an “as needed” basis, but not less than once a year. The purpose of this evaluation will be to determine the effectiveness of the Policies as well as to ensure compliance with state and federal regulations such as HIPAA.

This evaluation will occur annually, as well as when any of the following events occur:

- There is a change to any state or federal regulation that may affect the Security Policies
- There is a new state or federal regulation that may affect the Security Policies
- There has been a significant breach of security or other security incident within Creighton
- Any other time the Security Officer feels there is a need to evaluate the Security Policies

DEFINITIONS

Protected Health Information
Individually identifiable health information transmitted or maintained in any form.

Electronic Protected Health Information (ePHI)
Individually identifiable health information transmitted or maintained in electronic form.
**Evaluation**
An audit of the effectiveness and adherence to Creighton University policies and procedures.

**RESPONSIBILITIES**

Information Security Office is responsible for determining when an evaluation needs to be conducted and is responsible for overseeing the execution of the evaluation.

**ADMINISTRATION AND INTERPRETATIONS**

This policy shall be administered by Information Security. Questions regarding this policy should be directed to the Information Security Officer.

**AMENDMENT/TERMINATION OF THIS POLICY**

The University reserves the right to modify, amend or terminate this policy at any time. This policy does not constitute a contract between the University and its faculty or employees.

**REFERENCES TO APPLICABLE POLICIES**


**EXCEPTIONS**

None

**VIOLATIONS/ENFORCEMENT**

Any known violations of this policy should be reported to the University's Information Security Officer at 402-280-2386 or via e-mail to infosec@creighton.edu.

Violations of this policy can result in immediate withdrawal or suspension of system and network privileges and/or disciplinary action in accordance with University procedures.

The University may advise law enforcement agencies when a criminal offense may have been committed.
PURPOSE

The purpose of this policy is to comply with the Health Insurance Portability and Accountability Act (HIPAA) Security Rule’s requirements pertaining to the integrity, confidentiality, and availability of electronic protected health information (ePHI).

SCOPE

This policy covers all electronic protected health information (ePHI), which is a person’s identifiable health information. This policy covers all ePHI, which is available currently, or which may be created, used in the future. This policy applies to all faculty, staff, students, residents, postdoctoral fellows, and non-employees (including visiting faculty, courtesy, affiliate, and adjunct faculty, industrial personnel, and others) who collect, maintain, use, or transmit ePHI in connection with activities at Creighton University.

POLICY

Creighton University requires all Business Associate contracts and other arrangements be modified with Addendums or revised for compliance with the HIPAA Security Rule.

DEFINITIONS

**Protected Health Information**
Individually identifiable health information transmitted or maintained in any form.

**Electronic Protected Health Information (ePHI)**
Individually identifiable health information transmitted or maintained in electronic form.

**Business Associate**
An individual or entity that receives protected health information (PHI) from a covered entity, such as a medical practice, so that the business associate may perform services or functions, or assist in the performance of services or functions, on behalf of the covered entity. An employee of the covered entity or a member of the covered entity's own workforce is not considered a business associate but an independent contractor is.

**Business Associate Agreement**
A written contract, or other arrangement, that documents satisfactory assurances that a business associate will appropriately safeguard the PHI information in order to disclose PHI to the business associate.
RESPONSIBILITIES

Creighton workforce members who enter into agreements with business associates are responsible for ensuring appropriate Business Associate Agreements are used.

ADMINISTRATION AND INTERPRETATIONS

This policy shall be administered by Information Security. Questions regarding this policy should be directed to the Information Security Officer.

AMENDMENT/TERMINATION OF THIS POLICY

The University reserves the right to modify, amend or terminate this policy at any time. This policy does not constitute a contract between the University and its faculty or employees.

REFERENCES TO APPLICABLE POLICIES


EXCEPTIONS

None

VIOLATIONS/ENFORCEMENT

Any known violations of this policy should be reported to the University's Information Security Officer at 402-280-2386 or via e-mail to infosec@creighton.edu.

Violations of this policy can result in immediate withdrawal or suspension of system and network privileges and/or disciplinary action in accordance with University procedures.

The University may advise law enforcement agencies when a criminal offense may have been committed.
Policies and Procedures

| SECTION: Administration | NO. 2.4.21.
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<th>ISSUED: 4/7/06</th>
<th>REV. A</th>
<th>REV. B</th>
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| POLICY: Contingency Operations Policy | PAGE 1 OF 2 |

PURPOSE

The purpose of this policy is to comply with the Health Insurance Portability and Accountability Act (HIPAA) Security Rule’s requirements pertaining to the integrity, confidentiality, and availability of electronic protected health information (ePHI).

Specifically HIPAA Security Rule section 164.310(a)(2)(i).

SCOPE

This policy covers all electronic protected health information (ePHI), which is a person’s identifiable health information. This policy covers all ePHI, which is available currently, or which may be created, used in the future. This policy applies to all faculty, staff, students, residents, postdoctoral fellows, and non-employees (including visiting faculty, courtesy, affiliate, and adjunct faculty, industrial personnel, and others) who collect, maintain, use, or transmit ePHI in connection with activities at Creighton University.

POLICY

Creighton University requires the creation of procedures that allow facility access in support of restoration of lost data under the disaster recovery plan and emergency mode operations plan in the event of an emergency.

DEFINITIONS

Protected Health Information
Individually identifiable health information transmitted or maintained in any form.

Electronic Protected Health Information (ePHI)
Individually identifiable health information transmitted or maintained in electronic form.

RESPONSIBILITIES

Systems Administrators with physical control of systems that maintain ePHI are responsible for the creation of contingency operations procedures.

Information Security Officer is responsible for determining where contingency operations procedures are necessary and making sure they are maintained.
ADMINISTRATION AND INTERPRETATIONS

This policy shall be administered by Information Security. Questions regarding this policy should be directed to the Information Security Officer.

AMENDMENT/TERMINATION OF THIS POLICY

The University reserves the right to modify, amend or terminate this policy at any time. This policy does not constitute a contract between the University and its faculty or employees.

REFERENCES TO APPLICABLE POLICIES


EXCEPTIONS

None

VIOLATIONS/ENFORCEMENT

Any known violations of this policy should be reported to the University's Information Security Officer at 402-280-2386 or via e-mail to infosec@creighton.edu.

Violations of this policy can result in immediate withdrawal or suspension of system and network privileges and/or disciplinary action in accordance with University procedures.

The University may advise law enforcement agencies when a criminal offense may have been committed.
### Policies and Procedures

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<td>CHAPTER: Information Technology</td>
<td>ISSUED: 4/7/06</td>
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**POLICY:** Facility Security Policy

**PAGE 1 OF 2**

### PURPOSE

The purpose of this policy is to comply with the Health Insurance Portability and Accountability Act (HIPAA) Security Rule’s requirements pertaining to the integrity, confidentiality, and availability of electronic protected health information (ePHI).

### SCOPE

This policy covers all electronic protected health information (ePHI), which is a person’s identifiable health information. This policy covers all ePHI, which is available currently, or which may be created, used in the future. This policy applies to all faculty, staff, students, residents, postdoctoral fellows, and non-employees (including visiting faculty, courtesy, affiliate, and adjunct faculty, industrial personnel, and others) who collect, maintain, use, or transmit ePHI in connection with activities at Creighton University.

### POLICY

Creighton University requires the development of a Facility Security Plan with the objective of safeguarding facilities and premises that house systems that maintain ePHI, from unauthorized physical access, tampering or theft including the equipment present in all such facilities.

### DEFINITIONS

- **Protected Health Information**
  Individually identifiable health information transmitted or maintained in any form.

- **Electronic Protected Health Information (ePHI)**
  Individually identifiable health information transmitted or maintained in electronic form.

### RESPONSIBILITIES

- Systems Administrators with physical control of systems that maintain ePHI are responsible for the creation of a facility security plan.

- Information Security Officer is responsible for determining where facility security plans are necessary and making sure they are maintained.
ADMINISTRATION AND INTERPRETATIONS

This policy shall be administered by Information Security. Questions regarding this policy should be directed to the Information Security Officer.

AMENDMENT/TERMINATION OF THIS POLICY

The University reserves the right to modify, amend or terminate this policy at any time. This policy does not constitute a contract between the University and its faculty or employees.

REFERENCES TO APPLICABLE POLICIES


EXCEPTIONS

None

VIOLATIONS/ENFORCEMENT

Any known violations of this policy should be reported to the University's Information Security Officer at 402-280-2386 or via e-mail to infosec@creighton.edu.

Violations of this policy can result in immediate withdrawal or suspension of system and network privileges and/or disciplinary action in accordance with University procedures.

The University may advise law enforcement agencies when a criminal offense may have been committed.
Policies and Procedures

SECTION: Administration

CHAPTER: Information Technology

POLICY: Access Control Policy

PURPOSE

The purpose of this policy is to comply with the Health Insurance Portability and Accountability Act (HIPAA) Security Rule’s requirements pertaining to the integrity, confidentiality, and availability of electronic protected health information (ePHI).

SCOPE

This policy covers all electronic protected health information (ePHI), which is a person’s identifiable health information. This policy covers all ePHI, which is available currently, or which may be created, used in the future. This policy applies to all faculty, staff, students, residents, postdoctoral fellows, and non-employees (including visiting faculty, courtesy, affiliate, and adjunct faculty, industrial personnel, and others) who collect, maintain, use, or transmit ePHI in connection with activities at Creighton University.

POLICY

Creighton University will control access to its information assets and systems. Only individuals that have been formally authorized to view or change sensitive information will be granted access to that information.

The fundamental principal of “need to know” will be applied within Creighton University to determine access privileges. Access to ePHI will be granted only if that individual has a legitimate need for the information. Reasonable efforts will be made to limit the amount of information to the minimum necessary needed to accomplish the intended purpose of the use, disclosure, or request.

DEFINITIONS

Protected Health Information
Individually identifiable health information transmitted or maintained in any form.

Electronic Protected Health Information (ePHI)
Individually identifiable health information transmitted or maintained in electronic form.

RESPONSIBILITIES

Systems Administrators are responsible for determining who needs physical access to the systems that maintain, transmit, or process ePHI.

Information Security Officer is responsible for validating the University’s adherence to this policy.
ADMINISTRATION AND INTERPRETATIONS

This policy shall be administered by Information Security. Questions regarding this policy should be directed to the Information Security Officer.

AMENDMENT/TERMINATION OF THIS POLICY

The University reserves the right to modify, amend or terminate this policy at any time. This policy does not constitute a contract between the University and its faculty or employees.

REFERENCES TO APPLICABLE POLICIES


EXCEPTIONS

None

VIOLATIONS/ENFORCEMENT

Any known violations of this policy should be reported to the University's Information Security Officer at 402-280-2386 or via e-mail to infosec@creighton.edu.

Violations of this policy can result in immediate withdrawal or suspension of system and network privileges and/or disciplinary action in accordance with University procedures.

The University may advise law enforcement agencies when a criminal offense may have been committed.
PURPOSE

The purpose of this policy is to comply with the Health Insurance Portability and Accountability Act (HIPAA) Security Rule’s requirements pertaining to the integrity, confidentiality, and availability of electronic protected health information (ePHI).

SCOPE

This policy covers all electronic protected health information (ePHI), which is a person’s identifiable health information. This policy covers all ePHI, which is available currently, or which may be created, used in the future. This policy applies to all faculty, staff, students, residents, postdoctoral fellows, and non-employees (including visiting faculty, courtesy, affiliate, and adjunct faculty, industrial personnel, and others) who collect, maintain, use, or transmit ePHI in connection with activities at Creighton University.

POLICY

Distributed systems administrators will identify the physical components that are essential to security. These systems administrators must oversee any security-relevant physical modifications. A maintenance record must be created for each modification made to the physical site, facility or building. Such information must be securely stored.

DEFINITIONS

Protected Health Information
Individually identifiable health information transmitted or maintained in any form.

Electronic Protected Health Information (ePHI)
Individually identifiable health information transmitted or maintained in electronic form.

RESPONSIBILITIES

Systems Administrators with physical control of systems that maintain ePHI are responsible for the adherence to this policy.

Information Security Officer is responsible for validating the University’s adherence to this policy.
Policies and Procedures

SECTION: Administration

CHAPTER: Information Technology

POLICY: Maintenance Record Policy

ADMINISTRATION AND INTERPRETATIONS

This policy shall be administered by Information Security. Questions regarding this policy should be directed to the Information Security Officer.

AMENDMENT/TERMINATION OF THIS POLICY

The University reserves the right to modify, amend or terminate this policy at any time. This policy does not constitute a contract between the University and its faculty or employees.

REFERENCES TO APPLICABLE POLICIES


EXCEPTIONS

None

VIOLATIONS/ENFORCEMENT

Any known violations of this policy should be reported to the University's Information Security Officer at 402-280-2386 or via e-mail to infosec@creighton.edu.

Violations of this policy can result in immediate withdrawal or suspension of system and network privileges and/or disciplinary action in accordance with University procedures.

The University may advise law enforcement agencies when a criminal offense may have been committed.
### Policies and Procedures

**SECTION:** Administration  
**NO.:** 2.4.25.  
**CHAPTER:** Information Technology  
**ISSUED:** 9/11/96  
**REV. A:** 6/26/00  
**REV. B:** 9/27/00  
**REV. C:** 8/18/04  
**REV. D:** 3/13/13  
**POLICY:** Acceptable Use Policy  

#### PURPOSE

The purpose of this document is to establish and promote the ethical, legal, and secure use of computing and electronic communications for all members of Creighton University.

#### SCOPE

This policy applies to all users of electronic resources owned or managed by Creighton University.

#### POLICY

All users of Creighton University electronic resources are expected to utilize such resources in a responsible, ethical and legal manner consistent with the Creighton University mission and policies. As such, all users are **required** to:

- Comply with published University and departmental policies governing the use, transfer, management, or handling of electronic resources.
- Use resources only for authorized purposes.
- Use only legal versions of copyrighted software in compliance with vendor license requirements.
- Protect university provided user account(s) from use by other individuals.
- Consent to monitoring for the purposes of enforcing University policies, troubleshooting network or system problems, or to aid in the investigation of legal or criminal matters.

All users are **prohibited** from:

- Using University electronic resources to impair, disrupt, or in any way damage Creighton University networks, computers, telephonic equipment, or external networks or computers.
- Attempting to circumvent or subvert system or network security measures.
- Unauthorized access to networks, computer systems, or data.
- The reproduction or use of legally protected content without consent from the author or rights holder.
- Using Creighton University electronic resources to interfere with or cause impairment to the activities of others.
- Using Creighton University electronic resources to harass or make threats to specific individuals, or a class of individuals.
• Using CU electronic resources in pursuit of unauthorized commercial or political activities, or for individual personal or financial gain.
• Using CU electronic resources to violate city, state, federal, or international laws, rules, regulations, rulings or orders, or to otherwise violate any Creighton policies.

While the University does not generally monitor or limit content of information transmitted, stored, or processed on the campus network or information systems, it reserves the right to access and review such information under certain conditions. These include: investigating performance deviations and system problems (with reasonable cause), determining if an individual is in violation of this policy, or, as may be necessary, to ensure that Creighton University is not subject to claims of institutional misconduct.

DEFINITIONS

Electronic Resources – All computer related equipment, computer systems, software, networks, facsimile machines, voicemail and other telecommunications facilities, as well as all information or data contained therein.

RESPONSIBILITIES

All users of university resources are responsible for adhering to this policy.

ADMINISTRATION AND INTERPRETATIONS

This policy shall be administered by Information Security. Questions regarding this policy should be directed to the Information Security Officer.

AMENDMENT/TERMINATION OF THIS POLICY

The University reserves the right to modify, amend or terminate this policy at any time. This policy does not constitute a contract between the University and its faculty or employees.

REFERENCES TO APPLICABLE STANDARDS

None
EXCEPTIONS

None

VIOLATIONS/ENFORCEMENT

Any known violations of this policy should be reported to the University's Information Security Officer at 402-280-2386 or via e-mail to infosec@creighton.edu.

Violations of this policy can result in immediate withdrawal or suspension of system and network privileges and/or disciplinary action in accordance with University procedures. The University may advise law enforcement agencies when a criminal offense may have been committed.
PURPOSE

The purpose is to implement physical safeguards for all workstations that access electronic protected health information (ePHI) and to restrict access to authorized users.

SCOPE

This policy applies to all Creighton University workforce members including, but not limited to full-time employees, part-time employees, trainees, volunteers, contractors, temporary workers, and anyone else granted access to sensitive information by Creighton University. In addition, this policy applies to all workstations and other computing devices owned or operated by Creighton University and any computing device that connects to Creighton University’s internal network.

POLICY

Creighton University requires reasonable physical safeguards be implemented for all workstations and other electronic devices that access ePHI. Physical safeguards should reasonably prevent the theft of or unauthorized access to electronic devices that access, store, or transmit ePHI. Physical safeguards must be implemented wherever the electronic devices exist.

DEFINITIONS

Protected Health Information
Individually identifiable health information transmitted or maintained in any form.

Electronic Protected Health Information (ePHI)
Individually identifiable health information transmitted or maintained in electronic form.

Physical Safeguards
Electronic or mechanical mechanisms that are used to reasonably prevent the theft or physical access to electronic devices.

Electronic Device
In this policy, electronic devices are workstations, PDAs, laptops, tablet PCs, USB Flash drives, backup media, floppy disks, removable hard drives, or any other device that has the capability to store, access, or transmit ePHI.
Distributed PC Technician
The individual that is responsible for the support of a specific area’s personal computers. Support may be handled by local employees of a department or handled by the Division of Information Technology (DoIT).

RESPONSIBILITIES

Covered entity’s workforce is responsible for following all procedures implemented in relation to this policy.

Distributed PC Technicians are responsible for ensuring the workstations under their realm of responsibility that access ePHI are reasonably protected to prevent the theft of or unauthorized access to electronic devices that access, store, or transmit ePHI.

Information Security Officer is responsible for verifying that reasonable protective measures have been implemented.

ADMINISTRATION AND INTERPRETATIONS

This policy shall be administered by Information Security. Questions regarding this policy should be directed to the Information Security Officer.

AMENDMENT/TERMINATION OF THIS POLICY

The University reserves the right to modify, amend or terminate this policy at any time. This policy does not constitute a contract between the University and its faculty or employees.

REFERENCES TO APPLICABLE POLICIES


EXCEPTIONS

None
### VIOLATIONS/ENFORCEMENT

Any known violations of this policy should be reported to the University's Information Security Officer at 402-280-2386 or via e-mail to infosec@creighton.edu.

Violations of this policy can result in immediate withdrawal or suspension of system and network privileges and/or disciplinary action in accordance with University procedures.

The University may advise law enforcement agencies when a criminal offense may have been committed.
PURPOSE

The purpose of this policy is to prevent the leakage of private or confidential data.

SCOPE

This policy applies to any media that stores Creighton data.

POLICY

Creighton University requires that prior to disposal or reuse of any media, the media must be destroyed or sanitized in accordance with the Data Destruction Standard. All destruction and sanitizing must be logged to indicate what was destroyed or sanitized, who performed the activity, date, and method of destruction or sanitization.

If destruction or sanitization is performed by a third party, they must use methods of destruction that comply with the Data Destruction Standard and certificates of destruction noting the specific media destroyed or sanitized must be provided by the third party and maintained by Creighton.

DEFINITIONS

Creighton Data - Any data owned or entrusted to Creighton University.

Media - Material on which data are or may be recorded, such as paper, punched cards, magnetic tape, magnetic disks (hard drives, floppy disks, etc.), solid state devices (USB thumb drives), or optical discs (CDs, DVDs, etc.).

Workforce Member - Any individual, who collects, maintains, uses, or transmits Creighton’s data in connection with activities at Creighton University.

RESPONSIBILITIES

Workforce members are responsible for following the Data Destruction Standard prior to disposal or reuse of storage devices.
## Policy: Media Disposal and Re-use Policy

### Administration and Interpretations

This policy shall be administered by Information Security. Questions regarding this policy should be directed to the Information Security Officer.

### Amendment/Termination of This Policy

The University reserves the right to modify, amend or terminate this policy at any time. This policy does not constitute a contract between the University and its faculty or employees.

### References to Applicable Policies

- Data Classification Policy
- Data Handling Policy
- Data Destruction Standard

### Exceptions

None

### Violations/Enforcement

Any known violations of this policy should be reported to the University's Information Security Officer at 402-280-2386 or via e-mail to infosec@creighton.edu.

Violations of this policy can result in immediate withdrawal or suspension of system and network privileges and/or disciplinary action in accordance with University procedures.

The University may advise law enforcement agencies when a criminal offense may have been committed.
PURPOSE

The purpose of this policy is to comply with the Health Insurance Portability and Accountability Act (HIPAA) Security Rule’s requirements pertaining to the integrity, confidentiality, and availability of electronic protected health information. This policy intends to

SCOPE

This policy covers all electronic protected health information (ePHI), which is a person’s identifiable health information. This policy covers all ePHI, which is available currently, or which may be created, used in the future. This policy applies to all faculty, staff, students, residents, postdoctoral fellows, and non-employees (including visiting faculty, courtesy, affiliate, and adjunct faculty, industrial personnel, and others) who collect, maintain, use, or transmit ePHI in connection with activities at Creighton University (CU).

POLICY

Creighton University requires that a record be maintained to identify movements of ePHI-related hardware and devices. The movement of hardware, electronic media and devices includes the receipt, removal, storage and/or disposal of ePHI systems. Such information will also include the identity of responsible persons associated with the movement.

Movements of mobile hardware, media, or devices does not have to be tracked, but ownership of this equipment must be recorded.

DEFINITIONS

Protected Health Information
Individually identifiable health information transmitted or maintained in any form.

Electronic Protected Health Information (ePHI)
Individually identifiable health information transmitted or maintained in electronic form.

Electronic Device
In this policy, electronic devices are workstations, PDAs, laptops, tablet PCs, USB Flash drives, backup media, floppy disks, removable hard drives, or any other device that has the capability to store, access, or transmit ePHI.
RESPONSIBILITIES

All individuals identified in the scope of this policy are responsible for compliance with this policy.

Systems Administrators are responsible for implementing procedures to track the movement of hardware, media, and devices that contain ePHI.

Information Security Officer is responsible for verifying the adherence of this policy.

ADMINISTRATION AND INTERPRETATIONS

This policy shall be administered by Information Security. Questions regarding this policy should be directed to the Information Security Officer.

AMENDMENT/TERMINATION OF THIS POLICY

The University reserves the right to modify, amend or terminate this policy at any time. This policy does not constitute a contract between the University and its faculty or employees.

REFERENCES TO APPLICABLE POLICIES


EXCEPTIONS

None

VIOLATIONS/ENFORCEMENT

Any known violations of this policy should be reported to the University's Information Security Officer at 402-280-2386 or via e-mail to infosec@creighton.edu.

Violations of this policy can result in immediate withdrawal or suspension of system and network privileges and/or disciplinary action in accordance with University procedures.

The University may advise law enforcement agencies when a criminal offense may have been committed.
PURPOSE

The purpose of this policy is to comply with the Health Insurance Portability and Accountability Act (HIPAA) Security Rule’s requirements pertaining to the integrity, confidentiality, and availability of electronic protected health information.

SCOPE

This policy covers all electronic protected health information (ePHI), which is a person’s identifiable health information. This policy covers all ePHI, which is available currently, or which may be created, used in the future. This policy applies to all faculty, staff, students, residents, postdoctoral fellows, and non-employees (including visiting faculty, courtesy, affiliate, and adjunct faculty, industrial personnel, and others) who collect, maintain, use, or transmit ePHI in connection with activities at Creighton University (CU).

POLICY

Creighton University requires that prior to the movement of any system that contains ePHI an exact, retrievable copy of the data will be created and tested. The backed up data must be stored in a secure location and ensure that the appropriate access controls are implemented to only allow authorized access to all such data.

DEFINITIONS

Protected Health Information
Individually identifiable health information transmitted or maintained in any form.

Electronic Protected Health Information (ePHI)
Individually identifiable health information transmitted or maintained in electronic form.

RESPONSIBILITIES

Systems Administrators are responsible for following this policy.

Information Security Officer is responsible for verifying adherence to this policy.
ADMINISTRATION AND INTERPRETATIONS

This policy shall be administered by Information Security. Questions regarding this policy should be directed to the Information Security Officer.

AMENDMENT/TERMINATION OF THIS POLICY

The University reserves the right to modify, amend or terminate this policy at any time. This policy does not constitute a contract between the University and its faculty or employees.

REFERENCES TO APPLICABLE POLICIES


EXCEPTIONS

None

VIOLATIONS/ENFORCEMENT

Any known violations of this policy should be reported to the University's Information Security Officer at 402-280-2386 or via e-mail to infosec@creighton.edu.

Violations of this policy can result in immediate withdrawal or suspension of system and network privileges and/or disciplinary action in accordance with University procedures.

The University may advise law enforcement agencies when a criminal offense may have been committed.
Policies and Procedures

SECTION: Administration

CHAPTER: Information Technology

POLICY: Unique User ID Policy

PURPOSE

The purpose of this policy is to comply with the Health Insurance Portability and Accountability Act (HIPAA) Security Rule’s requirements pertaining to the integrity, confidentiality, and availability of electronic protected health information (ePHI).

SCOPE

This policy covers all electronic protected health information (ePHI), which is a person’s identifiable health information. This policy covers all ePHI, which is available currently, or which may be created, used in the future. This policy applies to all faculty, staff, students, residents, postdoctoral fellows, and non-employees (including visiting faculty, courtesy, affiliate, and adjunct faculty, industrial personnel, and others) who collect, maintain, use, or transmit ePHI in connection with activities at Creighton University.

POLICY

Creighton University requires each individual that accesses sensitive information, such as ePHI, via computer will be granted some form of unique user identification, such as a login ID.

DEFINITIONS

Protected Health Information
Individually identifiable health information transmitted or maintained in any form.

Electronic Protected Health Information (ePHI)
Individually identifiable health information transmitted or maintained in electronic form.

RESPONSIBILITIES

Systems Administrators are responsible for the creating unique IDs for applications under their control.

Information Security Officer is responsible for validating the University’s adherence to this policy.

ADMINISTRATION AND INTERPRETATIONS

This policy shall be administered by Information Security. Questions regarding this policy should be directed to the Information Security Officer.
AMENDMENT/TERMINATION OF THIS POLICY

The University reserves the right to modify, amend or terminate this policy at any time. This policy does not constitute a contract between the University and its faculty or employees.

REFERENCES TO APPLICABLE POLICIES


EXCEPTIONS

None

VIOLATIONS/ENFORCEMENT

Any known violations of this policy should be reported to the University's Information Security Officer at 402-280-2386 or via e-mail to infosec@creighton.edu.

Violations of this policy can result in immediate withdrawal or suspension of system and network privileges and/or disciplinary action in accordance with University procedures.

The University may advise law enforcement agencies when a criminal offense may have been committed.
Policies and Procedures

SECTION: Administration

CHAPTER: Information Technology

POLICY: Emergency Access Policy

PURPOSE

The purpose of this policy is to comply with the Health Insurance Portability and Accountability Act (HIPAA) Security Rule’s requirements pertaining to the integrity, confidentiality, and availability of electronic protected health information (ePHI).

SCOPE

This policy covers all electronic protected health information (ePHI), which is a person’s identifiable health information. This policy covers all ePHI, which is available currently, or which may be created, used in the future. This policy applies to all faculty, staff, students, residents, postdoctoral fellows, and non-employees (including visiting faculty, courtesy, affiliate, and adjunct faculty, industrial personnel, and others) who collect, maintain, use, or transmit ePHI in connection with activities at Creighton University.

POLICY

Creighton University requires that access to systems containing ePHI used to provide patient treatment be made available to any caregiver in case of an emergency.

DEFINITIONS

Protected Health Information
Individually identifiable health information transmitted or maintained in any form.

Electronic Protected Health Information (ePHI)
Individually identifiable health information transmitted or maintained in electronic form.

RESPONSIBILITIES

Systems Administrators are responsible for identifying systems that contain ePHI used in the treatment of patients and making this data available during an emergency.

Information Security Officer is responsible for validating the University’s adherence to this policy.
ADMINISTRATION AND INTERPRETATIONS

This policy shall be administered by Information Security. Questions regarding this policy should be directed to the Information Security Officer.

AMENDMENT/TERMINATION OF THIS POLICY

The University reserves the right to modify, amend or terminate this policy at any time. This policy does not constitute a contract between the University and its faculty or employees.

REFERENCES TO APPLICABLE POLICIES


EXCEPTIONS

None

VIOLATIONS/ENFORCEMENT

Any known violations of this policy should be reported to the University's Information Security Officer at 402-280-2386 or via e-mail to infosec@creighton.edu.

Violations of this policy can result in immediate withdrawal or suspension of system and network privileges and/or disciplinary action in accordance with University procedures.

The University may advise law enforcement agencies when a criminal offense may have been committed.
**Policies and Procedures**

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**PURPOSE**

The purpose of this policy is to comply with the Health Insurance Portability and Accountability Act (HIPAA) Security Rule’s requirements pertaining to the integrity, confidentiality, and availability of electronic protected health information (ePHI).

**SCOPE**

This policy covers all electronic protected health information (ePHI), which is a person’s identifiable health information. This policy covers all ePHI, which is available currently, or which may be created, used in the future. This policy applies to all faculty, staff, students, residents, postdoctoral fellows, and non-employees (including visiting faculty, courtesy, affiliate, and adjunct faculty, industrial personnel, and others) who collect, maintain, use, or transmit ePHI in connection with activities at Creighton University.

**POLICY**

Creighton University requires systems that contain or access ePHI adhere to an Automatic Logoff process after a period of inactivity.

The length of time that a user is allowed to stay logged on while idle will depend on the sensitivity of the information that can be accessed from that computer and the relative security of the environment that the system is located.

**DEFINITIONS**

- **Protected Health Information**
  Individually identifiable health information transmitted or maintained in any form.

- **Electronic Protected Health Information (ePHI)**
  Individually identifiable health information transmitted or maintained in electronic form.

**RESPONSIBILITIES**

- **Systems Administrators** are responsible for identifying systems that contain or access ePHI and implement an automated logoff process commensurate with the sensitivity of the information and physical location of the terminal.
Information Security Officer is responsible for validating the University’s adherence to this policy.

ADMINISTRATION AND INTERPRETATIONS

This policy shall be administered by Information Security. Questions regarding this policy should be directed to the Information Security Officer.

AMENDMENT/TERMINATION OF THIS POLICY

The University reserves the right to modify, amend or terminate this policy at any time. This policy does not constitute a contract between the University and its faculty or employees.

REFERENCES TO APPLICABLE POLICIES


EXCEPTIONS

None

VIOLATIONS/ENFORCEMENT

Any known violations of this policy should be reported to the University's Information Security Officer at 402-280-2386 or via e-mail to infosec@creighton.edu.

Violations of this policy can result in immediate withdrawal or suspension of system and network privileges and/or disciplinary action in accordance with University procedures.

The University may advise law enforcement agencies when a criminal offense may have been committed.
Policies and Procedures

SECTION: Administration
CHAPTER: Information Technology

POLICY: Encryption Standard Policy

PURPOSE

This standard provides the standard practices that must be followed when using encryption technology. Implementation of this standard ensures the consistent application of the guidelines utilized across all areas of the university, thereby benefiting the users and administrative functions.

The ability to require all users to abide by the same standard for using encryption will help to insure that Creighton information is adequately protected, non-repudiation is maintained and that data recovery is available.

SCOPE

This standard applies to all members of the Creighton community including all temporary and contract workers. It applies to all production computer systems used at Creighton, whether in the delivery of internal services to faculty, staff, and students; or to the delivery of services to external customers.

STANDARD

Creighton University strives to provide the highest level of security for all critical data while balancing the challenge of protecting “data at rest” such as that defined in the Access Control standard of the Health Insurance Portability and Accountability Act (HIPAA) Security Rule against the increase in security technology complexity and administrative overhead including performance considerations and usability.

Creighton University will seriously review the viability of securing critical database, file servers as well as ePHI on mobile devices such as laptops and PDAs.

Proven, standard algorithms such as DES, Blowfish, RSA, RC5 and IDEA should be used as the basis for encryption technologies. These algorithms represent the actual cipher used for an approved application.

Symmetric cryptosystem key lengths must be at least 56 bits.

Asymmetric crypto-system keys must be of a length that yields equivalent strength.

The use of proprietary encryption algorithms is not allowed for any purpose, unless reviewed by qualified experts outside of the vendor in question and approved by the Security Officer.

Creighton University will test encryption and decryption capabilities of products and systems to ensure proper functionality.
File Encryption
There were several requirements that the encryption solution had to meet in order to be approved for use within Creighton. These requirements include file level encryption and decryption, secure file delete, integration into the desktop and applications, friendly user interface, key recovery, support for several encryption algorithms and key strengths, with technology based on the industry standards.

E-Mail Encryption
Creighton is currently evaluating secure email solutions. In the meantime email should be viewed as insecure medium therefore confidential information should not be sent via email.

World Wide Web Traffic Encryption
The Secure Sockets Layer (SSL) protocol using 128-bit key lengths has been approved for use to encrypt web traffic.

Remote Access
The University approved method of remote access is based on VPN technology which forces all traffic through an encrypted tunnel. Therefore, all remote access traffic passed between the Creighton network and the end users is fully encrypted.

Password Encryption
Creighton's policies do not allow passwords to be sent across the network in 'clear text' format. Passwords must also not be listed in clear text for the purpose of automating a login sequence. All passwords must be stored and transmitted in an encrypted format by the OS, DBMS, or application.

DEFINITIONS

Cryptography
The art and science of keeping messages secure. In addition to offering confidentiality, cryptography is used to provide authentication, integrity, and non-repudiation.

Clear Text
Non-encrypted data

Non-repudiation
After you do it, you can't say you didn't
128-bit encryption
Encryption key that is 128 bits in length

SSL
The Secure Sockets Layer (SSL) is a commonly-used protocol for managing the security of a message transmission on the Internet. SSL uses the public-and-private key encryption system, which also includes the use of a digital certificate.

Digital Certificate
A digital certificate is an electronic "credit card" that establishes your credentials when doing business or other transactions on the Web. It is issued by a certification authority (CA). It contains your name, a serial number, expiration dates, a copy of the certificate holder's public key (used for encrypting messages and digital signatures), and the digital signature of the certificate-issuing authority so that a recipient can verify that the certificate is real

RESPONSIBILITIES

Information Security is responsible for evaluating and approving new encryption technologies and software, as well as reviewing and approving all requests to use cryptographic technology within Creighton. The Information Security Department is also responsible for maintaining and updating this standard as necessary.

Systems Administrators are responsible for obtaining and installing server side digital certificates that are used for server authentication in SSL transactions.

Network Users are responsible for adhering to the Cryptography Policy and Encryption Standard when handling Confidential Creighton University information.

REFERENCES TO APPLICABLE STANDARDS


EXCEPTIONS

None
Policies and Procedures

SECTION: Administration

CHAPTER: Information Technology

POLICY: Encryption Standard Policy

VIOLATIONS/ENFORCEMENT

Any known violations of this standard should be reported to the University's Information Security Officer at 402-280-2386 or via e-mail to infosec@creighton.edu.

Violations of this standard can result in immediate withdrawal or suspension of system and network privileges and/or disciplinary action in accordance with University policies.

The University may advise law enforcement agencies when a criminal offense may have been committed.
Policies and Procedures

SECTION: Administration

CHAPTER: Information Technology

POLICY: Audit Controls Policy

PURPOSE

The purpose of this policy is to comply with the Health Insurance Portability and Accountability Act (HIPAA) Security Rule’s requirements pertaining to the integrity, confidentiality, and availability of electronic protected health information (ePHI).

SCOPE

This policy covers all electronic protected health information (ePHI), which is a person’s identifiable health information. This policy covers all ePHI, which is available currently, or which may be created, used in the future. This policy applies to all faculty, staff, students, residents, postdoctoral fellows, and non-employees (including visiting faculty, courtesy, affiliate, and adjunct faculty, industrial personnel, and others) who collect, maintain, use, or transmit ePHI in connection with activities at Creighton University.

POLICY

Creighton University will identify critical systems that require event auditing capabilities. At a minimal, event auditing capabilities will be enabled on all systems that process, transmit, and/or store ePHI. Events to be audited may include, and are not limited to, logins, logouts, and file accesses, deletions and modifications.

DEFINITIONS

Protected Health Information
Individually identifiable health information transmitted or maintained in any form.

Electronic Protected Health Information (ePHI)
Individually identifiable health information transmitted or maintained in electronic form.

Event Auditing
The process of logging systems transactions to provide evidence of when transactions take place and who performed the transactions.

RESPONSIBILITIES

Systems Administrators are responsible for identifying systems that must be have auditing enabled, implementing such auditing, and review and secure storage of said logs.
Information Security Officer is responsible for validating the University’s adherence to this policy.

ADMINISTRATION AND INTERPRETATIONS

This policy shall be administered by Information Security. Questions regarding this policy should be directed to the Information Security Officer.

AMENDMENT/TERMINATION OF THIS POLICY

The University reserves the right to modify, amend or terminate this policy at any time. This policy does not constitute a contract between the University and its faculty or employees.

REFERENCES TO APPLICABLE POLICIES


EXCEPTIONS

None

VIOLATIONS/ENFORCEMENT

Any known violations of this policy should be reported to the University's Information Security Officer at 402-280-2386 or via e-mail to infosec@creighton.edu.

Violations of this policy can result in immediate withdrawal or suspension of system and network privileges and/or disciplinary action in accordance with University procedures.

The University may advise law enforcement agencies when a criminal offense may have been committed.
Policies and Procedures

SECTION: Administration

CHAPTER: Information Technology

POLICY: Integrity Control Policy

PURPOSE

The purpose of this policy is to comply with the Health Insurance Portability and Accountability Act (HIPAA) Security Rule’s requirements pertaining to the integrity, confidentiality, and availability of electronic protected health information (ePHI).

SCOPE

This policy covers all electronic protected health information (ePHI), which is a person’s identifiable health information. This policy covers all ePHI, which is available currently, or which may be created, used in the future. This policy applies to all faculty, staff, students, residents, postdoctoral fellows, and non-employees (including visiting faculty, courtesy, affiliate, and adjunct faculty, industrial personnel, and others) who collect, maintain, use, or transmit ePHI in connection with activities at Creighton University.

POLICY

Creighton University requires that critical ePHI be protected against unauthorized alteration or destruction.

DEFINITIONS

Protected Health Information
Individually identifiable health information transmitted or maintained in any form.

Electronic Protected Health Information (ePHI)
Individually identifiable health information transmitted or maintained in electronic form.

RESPONSIBILITIES

Systems Administrators are responsible for identifying critical ePHI and implementing procedures or mechanisms to protect against unauthorized alteration or destruction.

Information Security Officer is responsible for validating the University’s adherence to this policy.
ADMINISTRATION AND INTERPRETATIONS

This policy shall be administered by Information Security. Questions regarding this policy should be directed to the Information Security Officer.

AMENDMENT/TERMINATION OF THIS POLICY

The University reserves the right to modify, amend or terminate this policy at any time. This policy does not constitute a contract between the University and its faculty or employees.

REFERENCES TO APPLICABLE POLICIES


EXCEPTIONS

None

VIOLATIONS/ENFORCEMENT

Any known violations of this policy should be reported to the University's Information Security Officer at 402-280-2386 or via e-mail to infosec@creighton.edu.

Violations of this policy can result in immediate withdrawal or suspension of system and network privileges and/or disciplinary action in accordance with University procedures.

The University may advise law enforcement agencies when a criminal offense may have been committed.
PURPOSE

The purpose of this policy is to comply with the Health Insurance Portability and Accountability Act (HIPAA) Security Rule’s requirements pertaining to the integrity, confidentiality, and availability of electronic protected health information (ePHI).

SCOPE

This policy covers all electronic protected health information (ePHI), which is a person’s identifiable health information. This policy covers all ePHI, which is available currently, or which may be created, used in the future. This policy applies to all faculty, staff, students, residents, postdoctoral fellows, and non-employees (including visiting faculty, courtesy, affiliate, and adjunct faculty, industrial personnel, and others) who collect, maintain, use, or transmit ePHI in connection with activities at Creighton University.

POLICY

To ensure that all individuals or entities that access ePHI have been appropriately authenticated the following procedures must be implemented:

- Workforce members seeking access to any network, system, or application that contains ePHI must satisfy a user authentication mechanism such as a unique user identification and password, biometric input, or a user identification smart card to verify their authenticity.
- Workforce members seeking access to any network, system, or application must not misrepresent themselves by using another person’s User ID and Password, smart card, or other authentication information.
- Workforce members are not permitted to allow other persons or entities to use their unique User ID and password, smart card, or other authentication information.
- A reasonable effort must be made to verify the authenticity of the receiving person or entity prior to transmitting EPHI.

DEFINITIONS

Protected Health Information
Individually identifiable health information transmitted or maintained in any form.

Electronic Protected Health Information (ePHI)
Individually identifiable health information transmitted or maintained in electronic form.
**Policies and Procedures**

**SECTION:** Administration

**CHAPTER:** Information Technology

**POLICY:** Person or Entry Authentication Policy

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**Workforce Member**
Any Staff, Faculty, Student, or designated 3rd party resource that works with ePHI

**RESPONSIBILITIES**

- **Network users** are responsible for adhering to this policy.

- **Administrators of systems that maintain PHI** are responsible for ensuring the policies statements detailed above are implemented on all systems that store, transmit, or maintain PHI.

- **Information Security Officer** is responsible for verifying that an authentication mechanism on systems that store, transmit, or maintain PHI are functional, appropriate and reasonably mitigate the risk of unauthorized access.

**ADMINISTRATION AND INTERPRETATIONS**
This policy shall be administered by Information Security. Questions regarding this policy should be directed to the Information Security Officer.

**AMENDMENT/TERMINATION OF THIS POLICY**
The University reserves the right to modify, amend or terminate this policy at any time. This policy does not constitute a contract between the University and its faculty or employees.

**REFERENCES TO APPLICABLE POLICIES**

**EXCEPTIONS**
None
Policies and Procedures

SECTION: Administration

CHAPTER: Information Technology

POLICY: Person or Entry Authentication Policy

VIOLATIONS/ENFORCEMENT

Any known violations of this policy should be reported to the University's Information Security Officer at 402-280-2386 or via e-mail to infosec@creighton.edu.

Violations of this policy can result in immediate withdrawal or suspension of system and network privileges and/or disciplinary action in accordance with University procedures.

The University may advise law enforcement agencies when a criminal offense may have been committed.
Policies and Procedures

SECTION: Administration

CHAPTER: Information Technology

POLICY: Transmission Integrity Policy

PURPOSE

The purpose of this policy is to comply with the Health Insurance Portability and Accountability Act (HIPAA) Security Rule’s requirements pertaining to the integrity, confidentiality, and availability of electronic protected health information (ePHI).

SCOPE

This policy covers all electronic protected health information (ePHI), which is a person’s identifiable health information. This policy covers all ePHI, which is available currently, or which may be created, used in the future. This policy applies to all faculty, staff, students, residents, postdoctoral fellows, and non-employees (including visiting faculty, courtesy, affiliate, and adjunct faculty, industrial personnel, and others) who collect, maintain, use, or transmit ePHI in connection with activities at Creighton University.

POLICY

Creighton University will maintain integrity controls to ensure the validity of information transmitted over the network infrastructure.

Creighton University will determine the information transmitted over open and other networks for such data integrity is a requirement. This information includes, but is not limited to ePHI.

Creighton University will determine the types of integrity controls to implement to secure ePHI transmitted over open and other networks.

DEFINITIONS

Protected Health Information
Individually identifiable health information transmitted or maintained in any form.

Electronic Protected Health Information (ePHI)
Individually identifiable health information transmitted or maintained in electronic form.

RESPONSIBILITIES

Systems Administrators are responsible for identifying critical ePHI and implementing procedures or mechanisms to adhere to this policy.
Information Security Officer is responsible for validating the University’s adherence to this policy.

ADMINISTRATION AND INTERPRETATIONS

This policy shall be administered by Information Security. Questions regarding this policy should be directed to the Information Security Officer.

AMENDMENT/TERMINATION OF THIS POLICY

The University reserves the right to modify, amend or terminate this policy at any time. This policy does not constitute a contract between the University and its faculty or employees.

REFERENCES TO APPLICABLE POLICIES


EXCEPTIONS

None

VIOLATIONS/ENFORCEMENT

Any known violations of this policy should be reported to the University's Information Security Officer at 402-280-2386 or via e-mail to [infosec@creighton.edu](mailto:infosec@creighton.edu).

Violations of this policy can result in immediate withdrawal or suspension of system and network privileges and/or disciplinary action in accordance with University procedures.

The University may advise law enforcement agencies when a criminal offense may have been committed.
PURPOSE

The purpose of this policy is to protect the confidentiality and integrity of sensitive information that may be sent or received in e-mail.

SCOPE

This policy applies to electronic messages sent from or received by any email address administered or maintained under the Creighton domain.

POLICY

Use of email systems at Creighton University (CU) is governed by the Acceptable Use.

The University reserves the right to monitor any and all email communications sent or received through the University email system without prior notice. Pursuant to this and the Data Handling Policy, all messages will be scanned and those of a confidential or sensitive nature may be automatically encrypted before being delivered to external parties.

Bulk mail should be sent to existing CU list serve (lists) where authorization procedures exist. In cases where CU lists cannot be used, unsolicited bulk emails may not be sent to members of the University community without authorization from the appropriate owner of each group (owners of each group of CU constituents is defined in the CU list serve environment).

1. Schools and academic departments are authorized to send messages to their students, faculty, or staff without further approval.
2. Public relations, Office of the President, and the Division of Information Technology are authorized to send messages to all students, faculty, or staff without further approval.
3. Human Resources is authorized to send messages to all employees without further approval.
4. Academic Affairs is authorized to send messages to all students without further approval.

DEFINITIONS

**Bulk Mail**
Messages sent to a large number of recipients for effective, efficient, and environmentally-friendly communication.
**Policies and Procedures**

**SECTION:** Administration  
**NO.:** 2.4.38.  

**CHAPTER:** Information Technology  
**ISSUED:** 4/7/06  
**REV. A:** 3/13/13  

**POLICY:** Email Policy  
**REV. B:**  
**PAGE 2 OF 2**

---

**Unsolicited Mail**  
Email sent to entities that have not previously explicitly or implicitly indicated consent to receive such messages either by indicating consent in a form or application, or through membership in a particular group or activity.

**RESPONSIBILITIES**

Each department is responsible for developing internal controls to handle the approval and distribution of messages to its constituents in accordance with this policy.

**ADMINISTRATION AND INTERPRETATIONS**

This policy shall be administered by Information Security. Questions regarding this policy should be directed to the Information Security Officer.

**AMENDMENT/TERMINATION OF THIS POLICY**

The University reserves the right to modify, amend or terminate this policy at any time. This policy does not constitute a contract between the University and its faculty or employees.

**REFERENCES TO APPLICABLE POLICIES**

- Acceptable Use Policy
- Data Handling Policy
- Email Encryption Standard

**EXCEPTIONS**

None

**VIOLATIONS/ENFORCEMENT**

Any known violations of this policy should be reported to the University's Information Security Officer at 402-280-2386 or via e-mail to infosec@creighton.edu.

Violations of this policy can result in immediate withdrawal or suspension of system and network privileges and/or disciplinary action in accordance with University procedures.

The University may advise law enforcement agencies when a criminal offense may have been committed.
PURPOSE

The purpose of this policy is to protect the confidentiality and integrity of sensitive information such as electronic protected health information (ePHI) that may be sent or received via email.

SCOPE

This policy applies to all Creighton University workforce members including, but not limited to full-time employees, part-time employees, trainees, volunteers, contractors, temporary workers, and anyone else granted access to sensitive information by Creighton University. In addition, this policy applies to all workstations and other computing devices owned or operated by Creighton University and any computing device that connects to Creighton University’s internal network.

STANDARD

The standard for network protocols in Creighton’s infrastructure is TCP/IP.

Creighton University will:

- Use encryption as much as possible to protect data
- Use firewall(s) to secure critical segments
- Deploy Intrusion Detection Systems (IDS) and Intrusion Prevention Systems (IPS) on all critical segments
- Disable all services that are not in use or services that have use of which you are not sure

DEFINITIONS

Protected Health Information
Individually identifiable health information transmitted or maintained in any form.

Electronic Protected Health Information (ePHI)
Individually identifiable health information transmitted or maintained in electronic form.

RESPONSIBILITIES

Information Security Officer is responsible for the creation of procedures required to support this policy and for supporting and ensuring compliance by workforce members.
ADMINISTRATION AND INTERPRETATIONS

This policy shall be administered by Information Security. Questions regarding this policy should be directed to the Information Security Officer.

AMENDMENT/TERMINATION OF THIS POLICY

The University reserves the right to modify, amend or terminate this policy at any time. This policy does not constitute a contract between the University and its faculty or employees.

REFERENCES TO APPLICABLE POLICIES


EXCEPTIONS

None

VIOLATIONS/ENFORCEMENT

Any known violations of this policy should be reported to the University's Information Security Officer at 402-280-2386 or via e-mail to infosec@creighton.edu.

Violations of this policy can result in immediate withdrawal or suspension of system and network privileges and/or disciplinary action in accordance with University procedures.

The University may advise law enforcement agencies when a criminal offense may have been committed.
### PURPOSE

The purpose of this policy is to comply with the Health Insurance Portability and Accountability Act (HIPAA) Security Rule’s requirements pertaining to the integrity, confidentiality, and availability of electronic protected health information (ePHI).

### SCOPE

This policy covers all electronic protected health information (ePHI), which is a person’s identifiable health information. This policy covers all ePHI, which is available currently, or which may be created, used in the future. This policy applies to all faculty, staff, students, residents, postdoctoral fellows, and non-employees (including visiting faculty, courtesy, affiliate, and adjunct faculty, industrial personnel, and others) who collect, maintain, use, or transmit ePHI in connection with activities at Creighton University.

### POLICY

Creighton University requires access controls to validate all access by members of the workforce to facilities and systems that maintain ePHI. Access controls will be enforced to ensure no access to ePHI in any unauthorized manner.

### DEFINITIONS

- **Protected Health Information**
  Individually identifiable health information transmitted or maintained in any form.

- **Electronic Protected Health Information (ePHI)**
  Individually identifiable health information transmitted or maintained in electronic form.

- **Workforce Member**
  Any Staff, Faculty, Student, or designated 3rd party resource that works with ePHI

- **Access Controls**
  Technical or manual procedures to ensure access to ePHI are legitimate.
RESPONSIBILITIES

Systems Administrators with physical control of systems that maintain ePHI are responsible for the creation of facility access controls.

Information Security Officer is responsible for determining where access controls are necessary and making sure they are maintained.

ADMINISTRATION AND INTERPRETATIONS

This policy shall be administered by Information Security. Questions regarding this policy should be directed to the Information Security Officer.

AMENDMENT/TERMINATION OF THIS POLICY

The University reserves the right to modify, amend or terminate this policy at any time. This policy does not constitute a contract between the University and its faculty or employees.

REFERENCES TO APPLICABLE POLICIES


EXCEPTIONS

None

VIOLATIONS/ENFORCEMENT

Any known violations of this policy should be reported to the University's Information Security Officer at 402-280-2386 or via e-mail to infosec@creighton.edu.

Violations of this policy can result in immediate withdrawal or suspension of system and network privileges and/or disciplinary action in accordance with University procedures.

The University may advise law enforcement agencies when a criminal offense may have been committed.
Policies and Procedures

SECTION: Administration

CHAPTER: Information Technology

POLICY: Computer-Based Application System Development Policy

PURPOSE

This policy provides guidelines for developing computer-based application systems. The intent of this policy is:

- To increase the likelihood that developed systems will be both effective (meet the needs of present and future users) and efficient (have a reasonable initial cost and reasonable operational, support, and enhancement costs).

- To assist in a clear understanding of, and agreement on, the roles that different departments should play in the development of a system.

- To help users and developers understand and agree on appropriate steps in the development process.

POLICY

1. The project responsibility of an application system resides with the department(s) that will use the system -- even for university-wide systems that Information Technology (IT) develops or operates.

2. Each application system should have a "primary department" (the department that will use the new system the most, or the one that is "responsible for" the data). For successful system development, it is important that the primary department have one or more individuals who will be able to spend sufficient time, over the life of the development process, on project-related work.

3. Where a unit of Information Technology plans to develop a system that will support multiple departments independently, the Vice President of Information Technology or his/her designee will notify all departments affected by the project. Interested departments will be required to volunteer to represent the user community. Information Technology will formally create a planning committee consisting of employees from user departments. The committee will determine the department responsible for the system for accountability purposes. The same process will be used when the University chooses to purchase a system.
4. Each application system should be developed using a structured methodology including the following phases:

   Phase I - Feasibility Analysis
   Phase II - Process Re-engineering/Requirements Definition
   Phase III - Detail Design/Vendor Selection
   Phase IV - Implementation
   Phase V - Post-Implementation Review and Procedures Updating

5. If a department is developing a computer-based application system and does not intend to follow some or all of the procedures, the department head should notify the Vice President of Information Technology of that intent. Information Technology will not ensure support for any application which does not conform to all applicable University information technology standards, particularly with respect to interoperability, accessibility, and communications compatibility.

SCOPE

This policy applies to all departments and covers both purchased vendor packages and systems created by in-house developers (programmers). Following this policy is particularly important if the system being developed is used for financial or management purposes.

PROCEDURES

The specific procedures to follow for each phase of the structured methodology are outlined in "Computer-Based Application System Development Policy and Procedures" maintained by the Vice President for Information Technology.

ADMINISTRATION AND INTERPRETATIONS

Questions regarding this policy should be addressed to the Vice President of Information Technology.
PURPOSE

To protect Creighton University from the inadvertent or deliberate violation of software licensing laws. To allow for better management and distribution of software and prevent redundancy.

SCOPE

This policy applies to all Creighton University employees using University-owned computer hardware and software.

POLICY

When possible, the University will purchase the academically priced, licensed software version instead of the boxed version. The Division of Information Technology (DoIT) is the custodian of all licensed software media.

DEFINITIONS

Media
Any means by which software is distributed for installation. Usually, but not limited to CD/DVD.

Boxed Software
Individual installation copy of software; product commonly found in retail stores.

Licensed Software
Academically-discounted software sold as a single or multi-user license; product cannot be purchased at retail store.

RESPONSIBILITIES

All users of Creighton computers are required to practice proper software licensing compliance.

ADMINISTRATION AND INTERPRETATIONS

This policy is jointly administered by Purchasing and DoIT. Questions regarding this policy should be addressed to the respective area.

Purchasing will purchase the software from a supplier; the supplier will issue a paper license or certificate to the requesting department. This certificate is the legal proof of purchase. Upon receipt of the certificate, the department will contact DoIT for installation of the software. Installation requests can be placed at pcwork.creighton.edu.
Should a department request a particular software version for which the University does not have media, the requesting department assumes the cost of the media.

The requesting department is responsible for securing the certificate at the Reinert Alumni Library to use as proof in case of software audit.

DoIT will loan media to distributed support technicians across campus on an as needed basis with proof of license.

**AMENDMENT/TERMINATION OF THIS POLICY**

The University reserves the right to modify, amend or terminate this policy at any time. This policy does not constitute a contract between the University and its faculty or employees.

**REFERENCES TO APPLICABLE POLICIES**

University Purchasing Policy 6.3 Departmental Computer Acquisition

**EXCEPTIONS**

None

**VIOLATIONS/ENFORCEMENT**

Any violations of this policy should be reported to Purchasing or the Division of Information Technology.

Violations of this policy can result in immediate withdrawal or suspension of system and network privileges, removal of the software and/or disciplinary action in accordance with University procedures.

The University may advise law enforcement agencies when a criminal offense may have been committed.
PURPOSE

The purpose of this policy is to establish an official means for University communications.

POLICY

The Creighton University assigned email account shall be the official means of communication with all students, faculty, and staff. All community members are responsible for all information sent to them via their University assigned email account. Members who choose to manually forward mail from their University email accounts are responsible for ensuring that all information, including attachments, is transmitted in its entirety to the preferred account.

All faculty, staff, and students are required to maintain an @creighton.edu computer account. This account provides both an online identification key and a University Official Email address. The University sends much of its correspondence solely through email. This includes, but is not limited to, policy announcements, emergency notices, meeting and event notifications, course syllabi and requirements, and correspondence between faculty, staff, and students. Such correspondence is mailed only to the University Official Email address.

Faculty, staff and students are expected to check their email on a frequent and consistent basis in order to stay current with University-related communications. Faculty, staff, and students have the responsibility to recognize that certain communications may be time-critical.

SCOPE

This communication strategy applies to all members of the University community -- faculty, staff, and students. Units with employees that have limited access to a computer are asked to post University notices in an easily accessible space.
PURPOSE

The purpose is to maintain compliance with the HIPAA Security Rule in written (or electronic) form as it relates to Creighton University policies and procedures, and if an action, activity or assessment is required, to maintain a written (which may be electronic) record of the action, activity or assessment.

SCOPE

This policy applies to Creighton University in its entirety, including all workforce members. Further, the policy applies to all systems, network, and applications, as well as all facilities, which process, store or transmit electronic protected health information (ePHI).

POLICY

Creighton University will retain the documentation required by the HIPAA Security Rule for 6 years from the date of its creation or the date when it was last in effect, whichever is later.

Creighton University will make documentation available to those persons responsible for implementing the procedures to which the documentation pertains.

The purpose is to review the documentation periodically, and update as needed, in response to environmental or operational changes affecting the security of the electronic protected health information.

DEFINITIONS

None

RESPONSIBILITIES

Information Security Officer will be responsible for ensuring the implementation of the requirements of the Documentation standard.
## Policies and Procedures

<table>
<thead>
<tr>
<th>SECTION: Administration</th>
<th>NO.</th>
<th>2.4.44.</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHAPTER: Information Technology</td>
<td>ISSUED:</td>
<td>5/2/07</td>
</tr>
<tr>
<td>POLICY: Documentation Policy</td>
<td>REV. A</td>
<td>REV. B</td>
</tr>
</tbody>
</table>

### ADMINISTRATION AND INTERPRETATIONS

This policy shall be administered by Information Security. Questions regarding this policy should be directed to the Information Security Officer.

### AMENDMENT/TERMINATION OF THIS POLICY

The University reserves the right to modify, amend or terminate this policy at any time. This policy does not constitute a contract between the University and its faculty or employees.

### REFERENCES TO APPLICABLE POLICIES

None

### EXCEPTIONS

None

### VIOLATIONS/ENFORCEMENT

Any known violations of this policy should be reported to the University's Information Security Officer at 402-280-2386 or via e-mail to infosec@creighton.edu.

Violations of this policy can result in immediate withdrawal or suspension of system and network privileges and/or disciplinary action in accordance with University procedures.

The University may advise law enforcement agencies when a criminal offense may have been committed.
Policies and Procedures

<table>
<thead>
<tr>
<th>SECTION: Administration</th>
<th>NO. 2.4.45.</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHAPTER: Information Technology</td>
<td>ISSUED: 3/18/09</td>
</tr>
<tr>
<td>POLICY: IT Prioritization Policy</td>
<td>PAGE 1 OF 3</td>
</tr>
</tbody>
</table>

PURPOSE

The Project Prioritization Policy is intended to ensure alignment of Information Technology (IT) spending with the University’s strategic goals and impose discipline and visibility to Creighton’s IT spending and investment. Project data are collected, organized and evaluated for the purpose of decision making, allocation of IT resources, analysis of return on investment, and the efficient management of all IT projects.

Project Prioritization allows management to evaluate, select and prioritize and continually manage all IT projects. Active IT projects will be updated and revised and may be accelerated, rescued, discontinued or reprioritized.

IT Project Prioritization:
- Demonstrates the University’s allocation of IT resources in support of its mission and programs.
- Documents the linkages among Creighton’s programs, strategies, and business processes and its use of IT.
- Demonstrates how investments in new projects balance, complement, and strengthen investments already being managed.
- Facilitates analysis of the risks associated with IT investments and helps ensure that appropriate risk mitigation strategies are adopted.
- Helps ensure that the University’s IT infrastructure as a whole, is effectively integrated.

SCOPE

The IT Prioritization Policy applies to the entire University including all programs, divisions, and schools where core University infrastructure is used. This policy is not to be used for standard replacement of computers.

POLICY

The Division of Information Technology (DoIT) will maintain an enterprise IT (information technology) project prioritization model. All divisions, departments, schools, and other Creighton University constituents will regularly submit and periodically update information about current and proposed information technology projects in the method described in the procedures section of this policy. The information in the project prioritization model will be used by the Vice President and CIO and executive management to conduct oversight and manage the University’s investments in information and communications technology.
**Policies and Procedures**

**SECTION:** Administration  
**NO.:** 2.4.45.  
**CHAPTER:** Information Technology  
**ISSUED:** 3/18/09  
**POLICY:** IT Prioritization Policy  
**PAGE 2 OF 3**

**PROCEDURES**

1. All IT related projects, regardless of funding source, must be submitted for entry into the prioritization model via the form in Appendix A and found online.

2. The Prioritization Committee will evaluate the project based on information provided and determine the impact on University strategic initiatives, financial and operational impact, as well as risks associated with doing and not doing the project. This information coupled with an evaluation of the availability of IT resources will produce a priority score for each project. As new projects are added to the prioritization model, the priority of all existing projects will be impacted.

3. All IT project managers across campus will keep their project data in the project prioritization model up to date. Decisions regarding availability of IT resources will be made based on current information in the model. The absence of accurate project information will lead to IT resources conflicts and overall scheduling and infrastructure shortages.

**DEFINITIONS**

**IT Resources**
This term loosely describes the wide range of information resources that the University uses and the equipment that we use to access, process and store information. Examples include: computers, servers, networks, software, email, IT technicians, etc.

**IT Projects**
IT projects are any effort to acquire or produce information and telecommunications technology systems and services, including all proposed expenditures for computing and telecommunications hardware and software, security for that hardware and software, and related consulting or other professional services.

**IT Systems**
All computing and telecommunications hardware and software, the activities undertaken to secure that hardware and software, and the activities undertaken to acquire, transport, process, analyze, store, and disseminate information electronically.
IT Prioritization Model
The IT prioritization model is the combination of all projects into a single matrix to provide a University wide view of all projects. It is important to note that the term does not mean only a project that impacts or serves the whole University, smaller departmental or divisional projects must also be included.

RESPONSIBILITIES

The Vice President and CIO is responsible for maintenance of the Project Prioritization Model.

Project Managers, whether identified formally or informally, are responsible for maintaining current project information within the prioritization model.

ADMINISTRATION AND INTERPRETATIONS

This policy shall be administered by the Office of the Chief Information Officer. Questions regarding this policy should be directed to the Vice President and CIO (402-280-2202).

AMENDMENT/TERMINATION OF THIS POLICY

The University reserves the right to modify, amend or terminate this policy at any time. This policy does not constitute a contract between the University and its faculty or employees.

REFERENCES TO APPLICABLE POLICIES

None

EXCEPTIONS

None

VIOLATIONS/ENFORCEMENT

Any known violations of this policy should be reported to the Vice President and CIO (402-280-2202).

Violations of this policy can result in immediate withdrawal or suspension of system and network privileges and/or disciplinary action in accordance with University procedures.
Creighton University Project Prioritization Score Sheet

Section 1: General Project Information

<table>
<thead>
<tr>
<th>Project Name:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Project Description:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Submitted By:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Client Contact:</td>
<td></td>
</tr>
<tr>
<td>Department/Division:</td>
<td></td>
</tr>
<tr>
<td>Requested Completion Date:</td>
<td></td>
</tr>
</tbody>
</table>

Section 2: Project Classification

<table>
<thead>
<tr>
<th>Project Category:</th>
<th>Regulatory/Legal Mandate 1</th>
<th>Total Prioritization Score: (Tally from score sheet – highest possible score = 51)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Select One)</td>
<td>Operation Infrastructure 2</td>
<td>Total Score =</td>
</tr>
<tr>
<td></td>
<td>Operational Efficiency</td>
<td>Priority:</td>
</tr>
<tr>
<td></td>
<td>Instructional Technology</td>
<td>□ High</td>
</tr>
<tr>
<td></td>
<td>Administrative Computing</td>
<td>□ Medium</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ Low</td>
</tr>
</tbody>
</table>

1. A mandate is an initiative that a governmental authority or audit entity has imposed on Creighton University.

2. Initiative will implement required network/IT infrastructure enhancements or adopt industry standards in order for Creighton University to continue basic business operations.

Section 3: Prioritization Scoring Model

<table>
<thead>
<tr>
<th>Alignment with Key Strategies</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Enhance and advance Creighton’s Catholic and Jesuit Identity</td>
<td></td>
</tr>
<tr>
<td>□ Enhance patient care, foster more effective ways of providing care</td>
<td></td>
</tr>
<tr>
<td>□ Foster, coordinate and communicate interdependent and innovative use of institutional human and financial resources</td>
<td></td>
</tr>
<tr>
<td>□ Strengthen and deliver transformative undergraduate, graduate and professional education in a dynamic, technology enhanced, living-learning environment that “holistically” develops our students.</td>
<td></td>
</tr>
<tr>
<td>□ Conduct scholarly investigation of such a scope and character as to inform our teaching and to address problems of our community and the larger society in the context of our Catholic and Jesuit mission</td>
<td></td>
</tr>
<tr>
<td>□ Enhance our capacity to excel in teaching, research, scholarly excellence and service through recruitment and retention of the highest quality faculty, staff and administrators</td>
<td></td>
</tr>
</tbody>
</table>
### Financial Impact Criteria

<table>
<thead>
<tr>
<th>Score</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>1&lt;sup&gt;st&lt;/sup&gt; Year Financial Benefit</td>
<td>&lt; $1K</td>
<td>≥ $1K &amp; &lt; $50 K</td>
<td>≥ $1K &amp; &lt; $50 K</td>
<td>≥ $1K &amp; &lt; $50 K</td>
<td>≥ $1K &amp; &lt; $50 K</td>
<td>≥ $1K &amp; &lt; $50 K</td>
</tr>
<tr>
<td>Project Expense 5</td>
<td>≥ $100K</td>
<td>≥ $75K &amp; &lt; $100K</td>
<td>≥ $50K &amp; &lt; $75K</td>
<td>≥ $25K &amp; &lt; $50K</td>
<td>≥ $1K &amp; &lt; $25K</td>
<td>&lt; $1K</td>
</tr>
</tbody>
</table>

### Client Impact Criteria

<table>
<thead>
<tr>
<th>Score</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client Satisfaction Improvement in Area Addressed</td>
<td>None</td>
<td>Minimal</td>
<td></td>
<td>Moderate</td>
<td></td>
<td>Major</td>
</tr>
<tr>
<td>Overall University Impact 4</td>
<td>&lt; 5% of client base</td>
<td>5-10%</td>
<td>11-20%</td>
<td>21-40%</td>
<td>41-75%</td>
<td>&gt; 75%</td>
</tr>
</tbody>
</table>

Section 4: Addresses the percentage of the University including students, faculty and staff.

### Operation Impact Criteria

<table>
<thead>
<tr>
<th>Score</th>
<th>0</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Degree of Process and Quality Improvement</td>
<td>No Impact</td>
<td>Small</td>
<td>Moderate</td>
<td>Major</td>
<td>Critical/Reengineering Effort</td>
</tr>
<tr>
<td>Implementation of Future Changes Made Easier 5</td>
<td>No Impact to Future Changes</td>
<td>Little Impact to Future Changes</td>
<td>Some Impact to Future Changes</td>
<td>Moderate Impact to Future Changes</td>
<td>Major Impact to Future Changes</td>
</tr>
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</table>

### Risk Factor Criteria

<table>
<thead>
<tr>
<th>Score</th>
<th>5</th>
<th>3</th>
<th>1</th>
<th>0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Business Result Risk</td>
<td>Guaranteed Benefits</td>
<td>High Probability of Benefits Realized</td>
<td>Average Probability of Benefits Realized</td>
<td>Low Probability of Benefits Realized</td>
</tr>
<tr>
<td>Complexity of Initiative 5</td>
<td>No Complexity</td>
<td>Low Complexity</td>
<td>Medium Complexity</td>
<td>High Complexity</td>
</tr>
<tr>
<td>Skill set/Hardware 5</td>
<td>No Uncertainty</td>
<td>One Type of Uncertainty</td>
<td>Two Types of Uncertainty</td>
<td>Three Types of Uncertainty</td>
</tr>
</tbody>
</table>
Section 5: Criteria to be completed by or with input from Information Technology Services.

Project Prioritization Committee Structure:

Chair is Vice President for IT

2 representatives from Academic Affairs
2 representatives from Health Sciences
2 representatives Clinical Affairs
2 representatives Students (under grad/ professional)
1 representative from Information Technology
1 representative from University Relations
1 representative from Student Services
1 representative from Administration
1 representative from Finance
1 representative from Academic Council
1 representative from Campus Ministry

** Ex officio members include Senior Director Support Services, Senior Director Network, IT Security Officer, and the Vice President/CIO. General Counsel’s office will be present at meetings of the Project Prioritization Committee and will be consulted on subject matter as needed.**
Policies and Procedures

<table>
<thead>
<tr>
<th>SECTION: Information Technology</th>
<th>NO. 2.4.46</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHAPTER: General</td>
<td>5/11/11</td>
</tr>
<tr>
<td>POLICY: Data Center Utilization Policy</td>
<td></td>
</tr>
</tbody>
</table>

**PURPOSE**

The Data Center Utilization Policy is intended to leverage, to the fullest extent possible, the infrastructure resources of the Creighton University Data Center. The CU Data Center provide security and infrastructure resources unavailable elsewhere on campus. Use of the CU Data Center maximizes the University’s investment and is a major component of a safe, reliable, and secure computing environment.

**SCOPE**

The Data Center Utilization Policy applies to the entire University include all programs, divisions and schools.

**POLICY**

1. All servers will be virtualized in the CU Data Center unless there is a documented exception made by the Vice President for Information Technology.
2. All servers exempt by item one above will be housed in the CU Data Center unless there is a documented exception.
3. All equipment in the CU Data Center will utilize shared services (Backup, Restore, SAN, Fiber Channel, Network) to the fullest extent possible unless there is a documented exception.
4. Any new infrastructure resources incorporated into the CU Data Center environment will become a shared resource, available to all, unless there is a documented exception.

**PROCEDURES**

Contact DoIT Customer Services (402) 280-1111 and open a service ticket with a description of the requirements of the server to be purchased. The appropriate DoIT department will contact the requester to discuss new server requirements, server replacements, or the movement of existing servers. Coordinating and implementing projects could take up to 90 days so please plan accordingly.

The Creighton Purchasing Department has procedures in effect that will place a hold on all server, storage, and network equipment requests to ensure a review by DoIT has been accomplished in accordance with applicable University policies and procedures.
EXCEPTIONS

The Vice President for Information Technology may grant exceptions to this policy on an individual basis. Prior to granting such an exception, DoIT and Departmental representatives will evaluate available options in order to determine the best solution for the students, faculty, and staff and for protecting Creighton data. If a consensus on a solution cannot be reached, the Vice President of Information Technology will meet with and adjudicate any disagreements in order to make a final determination.

DEFINITIONS

Server
A server is a computer or computer program that manages access to a centralized resource or service in a network.

Data Center
A data center is a facility used to house computer systems and associated components, such as telecommunications and storage systems. It generally includes redundant or backup power supplies, redundant data communications connections, environmental controls (e.g., air conditioning, fire suppression) and security devices.

Virtualization
Virtualization is the creation of a virtual, rather than physical version of something, such as an operating system, a server, a storage device or network resources. Virtualization enables increased utilization of physical hardware while providing increased fault tolerance.

Infrastructure Resources
Examples of shared infrastructure resources include, but are not limited to: cabling, backup/restore hardware, firewalls, load balancers, network monitoring solutions, network switches, data storage, fiber channel switches, etc…

RESPONSIBILITIES

The Vice President for Information Technology is responsible for maintenance of the Data Center Utilization Policy.

ADMINISTRATION AND INTERPRETATIONS

The Office of the Vice President for Information Technology shall administer this policy. Questions regarding this policy should be directed to the Vice President for Information Technology (402- 280-2202).
### AMENDMENT/TERMINATION OF THIS POLICY

The University reserves the right to modify, amend or terminate this policy at any time. This policy does not constitute a contract between the University and its faculty or employees.

### REFERENCES TO APPLICABLE POLICIES

Creighton’s Purchasing Department’s Hardware and Software Purchasing Procedures

### VIOLATIONS/ENFORCEMENT

Any known violations of this policy should be reported to the Vice President for Information Technology (402-280-2202).

Violations of this policy can result in immediate withdrawal or suspension of system and network privileges and/or disciplinary action in accordance with University procedures.
**Policies and Procedures**

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**PURPOSE**

This policy is intended to ensure changes to Information Technology (IT) systems are managed in a rational and predictable manner so that staff and customers can plan accordingly.

**SCOPE**

This policy applies to all production IT resources of Creighton University regardless of who administers the systems or which division of the University they report.

**POLICY**

Every change to a Creighton production IT system such as: operating systems, computing hardware, networks, and applications is subject to the Change Management Policy and must follow the Change Management Operating Procedures.

A Change Advisory Board (CAB) will meet regularly to review change requests and to ensure that change reviews and communications are being satisfactorily performed.

**DEFINITIONS**

**Change**

Any alteration of an existing IT resource. Changes may be classified as minor, standard, or significant.

**Production IT System**

Any IT system which is relied upon for performing business functions whereby the loss would critically impact the ability for a group to perform their duties.

**Change Advisory Board**

A group that reviews and approves changes to the IT infrastructure.

**RESPONSIBILITIES**

**Change Requesters** are responsible for ensuring adherence to this policy and associated procedures when planning and executing changes to production IT resources.

**Change Advisory Board** is responsible for approving or denying all submitted requests for change.
ADMINISTRATION AND INTERPRETATIONS
This policy shall be administered by Information Security. Questions regarding this policy should be directed to the Information Security Officer.

AMENDMENT/TERMINATION OF THIS POLICY
The University reserves the right to modify, amend or terminate this policy at any time. This policy does not constitute a contract between the University and its faculty or employees.

REFERENCES TO APPLICABLE POLICIES
Change Advisory Board Operating Procedures

EXCEPTIONS
None

VIOLATIONS/ENFORCEMENT
Any known violations of this policy should be reported to the University's Information Security Officer at 402-280-2386 or via e-mail to infosec@creighton.edu.

Violations of this policy can result in immediate withdrawal or suspension of system and network privileges and/or disciplinary action in accordance with University procedures.

The University may advise law enforcement agencies when a criminal offense may have been committed.
**PURPOSE**

Protect University data and information systems by ensuring a consistent, secure configuration across devices.

**SCOPE**

This policy applies to all information systems at Creighton University, including but not limited to, desktops/laptops, servers, network equipment, printers, mobile devices, and storage systems that store, process, or transmit University data.

**POLICY**

Information systems that process, transmit, or store University data must be configured in accordance with the applicable standard for that class of device or system. Standards must be written and maintained by the area or team responsible for the management of the system in conjunction with the Information Security Office.

Standard software deployments, such as a database or web server, should have a standard configuration maintained by the group responsible for managing the software.

Before being deployed into production, a system must be certified to meet the applicable configuration standard in accordance with the **Certification and Accreditation Procedures**.

**DEFINITIONS**

**Device Managers**
Entity responsible for maintaining or managing a class of information systems.

**Configuration Standard**
A document or collection of documents that describe how a device should be configured.

**RESPONSIBILITIES**

**Device Managers** are responsible for developing and publishing configuration standards for the devices over which they have primary responsibility.

**The Information Security Office** is responsible for reviewing and approving the standards in conjunction with the Device Managers.
ADMINISTRATION AND INTERPRETATIONS
This policy shall be administered by Information Security. Questions regarding this policy should be directed to the Information Security Officer.

AMENDMENT/TERMINATION OF THIS POLICY
The University reserves the right to modify, amend or terminate this policy at any time. This policy does not constitute a contract between the University and its faculty or employees.

REFERENCES TO APPLICABLE POLICIES
- Change Management Policy
- Desktop configuration standard
- Server configuration standard
- Printer configuration standard
- Network device configuration standard
- Mobile device configuration standard

EXCEPTIONS
Any exception to this policy must be approved by the Information Security Office. Exceptions to applicable standards must be documented and maintained by the team responsible for the standards.

VIOLATIONS/ENFORCEMENT
Any known violations of this policy should be reported to the University's Information Security Officer at 402-280-2386 or via e-mail to infosec@creighton.edu.

Violations of this policy can result in immediate withdrawal or suspension of system and network privileges and/or disciplinary action in accordance with University procedures.

The University may advise law enforcement agencies when a criminal offense may have been committed.
PURPOSE

The purpose of this standard is to provide specific steps for secure destruction of Creighton data.

SCOPE

This document describes the steps necessary to destroy data or media in a secure manner.

STANDARDS

When University data is no longer needed it should be disposed of in a secure and responsible manner.

Paper Records

Confidential Data must be destroyed by one of the following methods:
- Cross-cut shredded to a particle size no larger than 4 x 30mm.
- Burned in a licensed incinerator.

Private Data must be destroyed by one of the following methods:
- Cross-cut shredded to a particle size no larger than 8 x 40mm.
- Burned in a licensed incinerator.

Public Data may be discarded by the following method:
- Recycled or disposed of in the trash.

Magnetic Media (i.e. floppy disks, hard drives, tape drives, etc.)

Confidential Data must be destroyed by one of the following methods:
- If the media is going to be reused or redeployed within the University the media must be overwritten with random data using a tool approved by the Information Security Office.
- If the media is going to be disposed of or recycled, one of the following methods must be followed:
  - Physically destroy floppy disks and tape drives by shredding the platters or tape by cross-cut shredder into particles no larger than 4 x 30mm
  - Physically destroy magnetic media through pulverizing or crushing by a device or vendor approved by the Information Security Office.
• If the media is going to be returned to the vendor, one of the following methods must be followed:
  o Media must be overwritten with random data using a tool approved by the Information Security Office.
  o A contract with the vendor that states the vendor will securely wipe the media prior to reuse or disposal.

Private Data must be destroyed by one of the following methods:
• If the media is going to be reused or redeployed within the University the media must be overwritten with random data using a tool approved by the Information Security Office.
• If the media is going to be disposed of or recycled, one of the following methods must be followed:
  o Physically destroy floppy disks and tape drives by shredding the platters or tape by cross-cut shredder into particles no larger than 8 x 40mm
  o Physically destroy magnetic media through pulverizing or crushing by a device or vendor approved by the Information Security Office.
• If the media is going to be returned to the vendor, one of the following methods must be followed:
  o Media must be overwritten with random data using a tool approved by the Information Security Office.
  o A contract with the vendor that states the vendor will securely wipe the media prior to reuse or disposal.

Public Data may be discarded by the following method:
• Recycled or disposed of in accordance with University Facilities Management Policies.

Optical Media (i.e. CDs, DVDs, etc.)

Confidential Data must be destroyed by the following method:
• Physically destroy media by shredding, grinding, or incineration by a device or vendor approved by the Information Security Office.

Private Data must be destroyed by the following method:
• Physically destroy media by shredding, grinding, or incineration by a device or vendor approved by the Information Security Office.

Public Data may be discarded by the following method:
• Recycled or disposed of in accordance with University Facilities Management Policies.
USB removable media without hard drives (i.e. thumb drives, memory sticks, etc.)

**Confidential Data must be destroyed by the following method:**
- Physically destroy media by shredding, disintegrate, or pulverize by a device or vendor approved by the Information Security Office.

**Private Data must be destroyed by one of the following methods:**
- Physically destroy media by shredding, disintegrate, or pulverize by a device or vendor approved by the Information Security Office.
- Securely wiped using software approved by the Information Security Office.

**Public Data may be discarded by the following method:**
- Recycled or disposed of in accordance with University Facilities Management Policies.

**Cell phones and other mobile devices must be destroyed by the following method:**
- Manually delete all data such as call logs, phone numbers, applications, account information, etc. and then reset the device to factory defaults.

**DEFINITIONS**

**CD** - Compact Disc: a class of media on which data are recorded by optical means.

**Destruction** - The result of actions taken to ensure that media cannot be reused as originally intended and that information is virtually impossible to recover or prohibitively expensive.

**Disintegration** - A physically destructive method of sanitizing media; the act of separating into component parts.

**Disposal** - The act of discarding media with no other sanitization considerations. This is most often done by paper recycling containing non-confidential information but may also include other media.

**DVD** - Digital Video Disc: a disc the same shape and size as a CD; but the DVD has a higher density and gives the option for data to be double-sided or double-layered.

**Hard Disk** - A rigid magnetic disk fixed permanently within a drive unit and used for storing data.

**Incineration** - A physically destructive method of sanitizing media; the act of burning completely to ashes.
Media - Material on which data are or may be recorded, such as paper, punched cards, magnetic tape, magnetic disks (hard drives, floppy disks, etc.), solid state devices (USB thumb drives), or optical discs (CDs, DVDs, etc.).

Optical Disks - A plastic disk that is “written” (encoded) and “read” using an optical laser device. The disc contains a highly reflective metal and uses bits to represent data by containing areas that reduce the effect of reflection when illuminated with a narrow-beam source, such as a laser diode.

Overwrite - Writing patterns of data on top of the data stored on a magnetic medium as a means of rendering the original data irretrievable.

Pulverization - A physically destructive method of sanitizing media; the act of grinding to a powder or dust.

Shred - A method of sanitizing media; the act of cutting or tearing into small particles.

Wipe - Process to remove information from media such that data recovery is not possible.

AMENDMENT/TERMINATION OF THIS STANDARD

The University reserves the right to modify, amend, or terminate this standard at any time.
PURPOSE

The purpose of this policy is to outline the appropriate mechanisms for safeguarding University data as it travels through the lifecycle of being created, received, transmitted, maintained, used, and destroyed.

SCOPE

This policy covers all data, electronic or otherwise, that is used, produced, owned and/or placed in the care of Creighton University and its affiliates.

POLICY

All University data must be associated with a Data Owner who is responsible for managing access to the data and that all standards and policies are followed for the duration of the data lifecycle. Data must be classified and labeled in accordance with the Data Classification Policy and the Data Labeling Standard. The handling and safeguards afforded to each classification level are as follows:

Confidential Data
Confidential Data must be protected at all times to the highest possible degree as is prudent or as is required by law. Guidelines for the protection of Confidential Data include, but are not limited to the following:

1. Collection/Creation
   a. Users should collect only the minimum necessary information required to perform business or academic functions.

2. Access
   a. Data Owners are responsible for defining which users or groups of users may have access to confidential data under their stewardship.
   b. Access to confidential data should be logged with sufficient detail to identify the individual who accessed the data and when.
   c. Where access to confidential data has been authorized, use of such data shall be limited to the purpose required to perform University business.
   d. Confidential data must not be disclosed to third parties outside the University without explicit authorization of the Data Owner.
3. Storage/Handling
   a. Confidential data must be maintained with sufficient controls to prevent access by unauthorized parties.
   b. Confidential data at rest must be protected in accordance to the Data Storage Standard.
   c. Entities entrusted with confidential data must go through annual data security training.
4. Transfer
   a. Confidential data must not be transmitted electronically without mechanisms to ensure the confidentiality and integrity of the transmitted data.
      i. For example, a file may be transferred using an encrypted transfer protocol such as SFTP to protect it while in transit.
      ii. Encryption levels must meet the minimum standard for confidential data as outlined in the Data Encryption Standard.
5. Destruction
   a. Once data has reached the end of its useful life at the University, as defined in the Data Retention Policy, it must be destroyed in accordance with the Data Destruction Standard.
   b. Confidential data must be sufficiently destroyed so that none of the original elements can be recovered, reused, or identified.

Private Data
A reasonable level of control should be applied to Private Data to prevent accidental or intentional disclosure to unauthorized parties. Guidelines for the protection of private data include, but are not limited to the following:

1. Collection/Creation
   a. Users should collect only the minimal amount of information required to perform business/academic functions.
2. Access
   a. Data Owners are responsible for defining which users or groups of users may have access to private data under their stewardship.
   b. Private data should not be openly shared outside of the University.
3. Storage/Handling
   a. Private data must be maintained with sufficient controls to prevent access by unauthorized parties.
   b. Private data at rest must be protected in accordance to the Data Storage Standard.
4. Transfer
   a. Private data should not be transmitted electronically without mechanisms to ensure the confidentiality and integrity of the transmitted data.
   b. Encryption levels must meet the minimum standard for private data as outlined in the Data Encryption Standard.

5. Destruction
   a. Once data has reached the end of its useful life at the University, as defined in the Data Retention Policy, it must be destroyed in accordance with the Data Destruction Standard.

Public Data
A minimal level of control should be applied to Public Data to prevent unauthorized alterations or deletion. Guidelines for the protection of public data include, but are not limited to the following:

1. Collection/Creation
   a. Users should collect only the minimal amount of information required to perform business/academic functions.

2. Access
   a. Public Data is free to be accessed by any individual with no special provisions
   b. Care must be taken to prevent unauthorized modification or destruction of any data.

3. Storage/Handling
   a. No special restrictions exist on the storage or handling of public data other than those required to prevent unauthorized modification or destruction.

4. Transfer
   a. Public data may be transmitted in any available format or mechanism.

5. Destruction
   a. Once data has reached the end of its useful life at the University, as defined in the Data Retention Policy, it must be destroyed in accordance with the Data Destruction Standard.
DEFINITIONS

Data Owners
Those who generate data or those to whom data are entrusted. Data owners assign the classification categories to their data, and have the primary responsibility for ensuring the appropriate use and security of the data. “Data Owners” is used as a term of art for the purpose of this and related University data policies, and does not refer to the actual legal ownership of particular data.

Data Custodian
Those who are authorized by the Data Owner to use or manipulate data. Data Custodians have the responsibility to adhere to all policies applicable to the data entrusted to them.

RESPONSIBILITIES

Data Owners have the following responsibilities:
1. Ensure that access and protection requirements are consistent with University policies and the data classifications are in place and responsive to business needs.
2. Ensure the accuracy and quality of all data within their stewardship.
3. Communicate data protection requirements to the Data Custodians.
4. Annually review with appropriate Data Custodians the current set of data access authorizations and, as appropriate, update access granted to each user.
5. Ensure that authorized users of highly sensitive data are trained on their responsibilities associated with their approved access to that data.
7. Ensure that data is properly identified and labeled in accordance with applicable standards and policies.

Data Custodians have the following responsibilities:
1. Protect data in their possession from unauthorized disclosure, access, alteration, destruction, or usage.
2. Use information systems in a manner consistent with University policies and procedures.

ADMINISTRATION AND INTERPRETATIONS

This policy shall be administered by Information Security. Questions regarding this policy should be directed to the Information Security Officer.
AMENDMENT/TERMINATION OF THIS POLICY

The University reserves the right to modify, amend or terminate this policy at any time. This policy does not constitute a contract between the University and its faculty or employees.

REFERENCES TO APPLICABLE POLICIES

Data Classification Policy
Data Retention Policy
Data Destruction Standard
Data Storage Standard
Data Encryption Standard
Data Labeling Standard

EXCEPTIONS

None

VIOLATIONS/ENFORCEMENT

Any known violations of this policy should be reported to the University's Information Security Officer at 402-280-2386 or via e-mail to infosec@creighton.edu.

Violations of this policy can result in immediate withdrawal or suspension of system and network privileges and/or disciplinary action in accordance with University procedures.

The University may advise law enforcement agencies when a criminal offense may have been committed.
**Policies and Procedures**

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**PURPOSE**

The purpose of this policy is to provide guidance for the approval levels required for University expenditures including the purchase of capital assets.

**POLICY**

All expenditure requests, including the purchase of capital assets, must be signed by at least two Creighton employees, one of whom must be responsible and/or affiliated with the organization number being charged. No one may approve payments or reimbursements to, or for the benefit of, oneself.

**Approval Authority:** Vice Presidents have approval authority for expenditures less than $150,000. Vice Presidents will designate approval authority within their division at the levels defined in the chart below. Typically, approvers will be managers of people and budgets.

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Additional approvals are required as follows:

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<td>Vice President for Finance and Senior Vice President for Operations and President</td>
<td>Greater than or equal to $150,000 and $250,000</td>
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<tr>
<td>and Board of Trustees</td>
<td>Greater than or equal to $500,000 (if unbudgeted expense or capital)</td>
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<tr>
<td>and Board of Trustees</td>
<td>Greater than or equal to $1 million</td>
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Please note that if the expenditure involves executing a contract, refer to University Guide to Policies, Policy 2.1.7., Contracts with Outside Groups, which contains contracting procedures and approvals required to enter into a contract.

The Purchasing Department policies for materials control and additional approval requirements for the purchase of technology, animals, hazardous waste and radioactive materials are found at [http://www.creighton.edu/admin/purchasing/policies/materials/index.php](http://www.creighton.edu/admin/purchasing/policies/materials/index.php).
In addition, multi-year vendor contract agreements with a committed spending above $1 million will be reviewed and approved by the responsible Board Committee and the Budget and Finance Committee of the Creighton University Board of Trustees.

**PROCEDURES**

1. **Sales Tax Exemption:** Goods or services delivered, used, or assigned into the state of Nebraska for Creighton University will be considered tax exempt.

   The Nebraska tax-exempt number is 5-000408697. All other states must be filed on a state-by-state basis. All purchasers/travelers engaged in University business should check with the Purchasing Department prior to departing for available tax exemptions. If requested, Purchasing can provide a copy to suppliers of the appropriate tax-exempt certificate.

2. **Equipment Needs:** All significant equipment needs (all greater than $10,000 and any others that are deemed necessary) should be reviewed against the current equipment inventory to ensure that the same equipment is not already available on campus. This is a federal government requirement for all equipment on federal grants.

3. **DPR and TER Documents:** Direct Payment Requests (DPR) and Travel and Business Expense Reports (TER) submitted for processing, that have not gone through the purchase order process, will, therefore, require the same levels of approvals as required when a purchase order is processed and issued. These invoices cannot be processed until all signatures and approvals have been obtained.

**SCOPE**

This policy applies to all University expenditures including capital assets.

**AMENDMENT OR TERMINATION OF THIS POLICY**

Creighton University reserves the right to modify, amend or terminate this policy at any time.


PURPOSE

Creighton University recognizes that donations of real property may involve unique issues that require special processing and increased oversight. The purpose of this policy is to provide guidance for the acquisition, holding and disposal of real estate gifts offered to Creighton University.

POLICY

Gifts of real estate offered to the University must be reviewed by the Vice President for Finance for environmental and financial issues prior to acceptance and once accepted, will be sold in a timely manner. Exceptions to this policy may be authorized by the Investment Committee of the Board of Directors.

The Investment Committee of the Board of Directors is to be advised of all real estate gifts valued at $500,000 or more and must approve all sales of real estate with an original gift value or sales price greater than $500,000.

SCOPE

This policy applies to donations of real property offered to Creighton University by any donor.

AMENDMENT OR TERMINATION OF THIS POLICY

Creighton University reserves the right to modify, amend or terminate this policy at any time.
**Policies and Procedures**

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**PURPOSE**

To provide for orderly and prompt transmittal of all gifts received by University departments to the Development Office for the purpose of proper recording and receipting, and to ensure compliance with regulations pertaining to charitable gift transactions as set forth by the Internal Revenue Service and other regulatory agencies.

**RESPONSIBILITIES**

The Development Office is responsible for collecting, recording, acknowledging, and reporting all gifts made to Creighton University. It is important that all gifts to Creighton be properly recorded and acknowledged by the Development Office. This provides assurance that the gift is allocated according to the donor's wishes, a receipt is sent to the donor, all gifts are recorded and reported as gift income, and gifts accepted are proper, and beneficial. It is imperative that all gifts be reviewed by Development to insure against improper gifts which are contrary to law or the mission of the University, or gifts which may put the University under a financial disadvantage.

**DEFINITIONS**

**Gift** - A gift is anything of value given as a donation to the University by an individual or organization. It includes contributions referred to as "grants" by foundations and corporations for which no goods or services are expected.

**In-kind Gifts** - Gifts of tangible assets such as equipment, furniture, works of art, books, manuscripts, real estate, commercial property, or other similar items which have an educational or artistic value.

**GIFT TRANSMITTAL**

When a department receives a gift the department should prepare a Gift Transmittal Form. This form should be filled out and signed by the department head and forwarded with the gift to the Development Office. A copy of this form should be retained by the department for its records. This should be done promptly to insure timely acknowledgement, recording, and deposit of the gift.
Cash or its equivalent (negotiable securities, etc.) should never be sent through campus mail, but should be hand-delivered to the Development Office, or it can be picked up if necessary. Any in-kind gifts should be fully described on the transmittal form, including the location of the gift.

After gifts have been recorded by the Development Office, they will be sent to the Business Office and applied for the purpose for which they were designated by the donor. Funds received by a particular department will be credited to that department.

EXCEPTIONS

There should be no exceptions to this policy. However, if special circumstances or questions arise, please contact the Director of Development or the Vice President for University Relations.
Gift Transmittal Form for Creighton University

1. Description of Gift: $___________ __________ (Shares of Stock)
   Other ____________________________

2. Donor Information:
   Name ______________________________
   Address ______________________________
   ______ City  ______ State  ______ ZIP

3. Gift Information:
   Restricted by Donor ______ Yes ______ No
   For What Purpose? ___________________
   Account Number ___________________
   Matching Gift Form Enclosed ________

4. Other Information About Donor: ________________________________
   ________________________________

5. Special Requests from the Donor: ________________________________
   ________________________________
   (Please enclose copies of all correspondence from donor.)

6. Name of Department or School: ________________________________
   Name of Employee Handling Gift: ____________________________ Phone: ____________
   ________________________________
   ________________________________
   Signature of Employee  Date of Receipt of Gift

Thank you very much for your cooperation and assistance with this gift. The Development Office will be happy to make arrangements to pick up cash or other negotiable items from you. Please do not send them through campus mail. Please retain a copy of this form for your records.
Policies and Procedures

SECTION: Financial

CHAPTER: General

POLICY: Solicitation of Private Gifts

PURPOSE

To provide for coordinated, professional and effective solicitation of constituents for support of the University, its schools and colleges, organizations, individual departments, centers and institutes.

RESPONSIBILITIES

The Development Office is responsible for the identification, cultivation and solicitation of constituents who may be asked to provide private gifts in support of the University's mission. It is important that the University maximize its fundraising by carefully matching donors' interests with institutional needs. A coordinated program of solicitation assures that donors are asked for support of the University in a timely and sensitive fashion.

The Development Office establishes solicitation strategies to meet the University's fund raising priorities as determined by the President and the Board of Directors. The Development Office works closely with the Deans to develop appropriate fund raising strategies for their constituencies, in keeping with overall University priorities.

While all solicitation of private gifts must be coordinated with the Development Office, all faculty and staff are encouraged to provide the Development Office with information which can assist in identifying, cultivating and soliciting constituents.

DEFINITIONS

Solicitation - Any appeal made by an employee, department, organization, school or college by mail, phone, or in-person for a gift that will be of direct financial benefit to the University.

Gift - A gift is anything of value given as a donation to the University by an individual or organization. It includes contributions referred to as "grants" by foundations and corporations for which no goods or services are expected.

In-kind Gifts - Gifts of tangible assets such as equipment, furniture, works of art, books, manuscripts, real estate, commercial property, or other similar items which have an educational or artistic value.

Constituents - Those entities that may be asked for a gift to support the University including: alumni, non-degree alumni, parents of current and former students, friends of the University, employees of the University, vendors to the University and local and national corporations and foundations.
**Policies and Procedures**

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**EXCEPTIONS**

Grant proposals submitted in response to a corporate or foundation request for proposals are exempt from this policy. If special circumstances or questions arise, please contact the Director of Development or the Vice President for University Relations.
The Nebraska law clearly is to the effect that where funds are collected or dedicated to a particular purpose, then such funds must be used for that purpose. To use such funds for other purposes would be a violation of Creighton's trusteeship in the management of the funds it holds in trust.

More specifically, Creighton's exemption for federal tax purposes is based upon its being an educational institution.

The funds of Creighton cannot and legally should not be diverted to other causes, no matter how worthy they are and even though such causes would be definitely of a worthwhile and charitable variety.

In view of the above, it goes without saying that this opinion means that Creighton is not in a position to rightfully make donations which might be made by business corporations which would be for the good of the City of Omaha or corporations which were working for the betterment of the City of Omaha.
ARTICLE I

The University commits itself to the creation of a chair permanently named in honor of the donor or another person or institution designated by the donor upon accepting contributions specifically designated for such purposes. All endowed chairs are to be funded with a minimum of $1,000,000.

Section 1. The University will make public announcement of an endowed chair when the funds are pledged, if agreeable to the donor. Otherwise, announcement will be made when the chair is inaugurated.

Section 2. An endowed chair may be inaugurated when at least $1,000,000 is received.

Section 3. An endowed chair is inaugurated by the President of the University. The occasion is to be marked by a suitable celebration at the University, honoring both the donor and the first incumbent.

Section 4. The donor may designate the College or other academic unit wherein his/her chair is to be established, and will consult with the administration regarding the most appropriate department(s). Chairs may be assigned to disciplines, but if so, should be defined widely, e.g., "American history," or "physical chemistry" rather than narrowly, e.g., "magnetic materials," or "Chaucerian literature." When the University rather than the donor, designates the discipline and the department(s) wherein a chair is established, the President is free to change this designation whenever the chair falls vacant.

Section 5. The endowed chair is known by its full title, e.g., "The Jack MacAllister Chair of Economics," while its incumbent is always given a shorter title, "MacAllister Professor of Economics."

Section 6. All funds received for endowed chairs are deposited in the Perpetual Endowment, Income Restricted.
ARTICLE II: ADMINISTRATION

Section 1. Each year the income from a chair's endowment may be divided: part being returned to the endowment to accrue against inflation, part being credited to the appropriate Department as full or partial recovery of the incumbent's salary, or being used for other expenses of the chair. The amount of endowment income available for recovery of salary will in each case vary depending upon the rate of income and the professor's salary. Recovery of salary will not necessarily increase Department funds.

Section 2. During the donor's lifetime, the incumbent shall provide him or her with an annual report of service, and copies of all publications.

Section 3. The incumbent of an endowed chair is always to be a member of the teaching and/or research faculty with the rank of professor. Appointment to an endowed chair shall be made by the President of Creighton University.
### Policies and Procedures

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**POLICY:**

**Sharing of Financial Information**

The Policy of Creighton University is that we will not solicit nor accept from other colleges and universities any information concerning future fees, tuition levels, or salaries. Moreover, we are not to provide such information beyond that which is contained in public reports from our Business Office.

Information concerning current fees may be provided or exchanged. Such information may be requested from the Business or Admissions Offices.

Information concerning current salaries and other aspects of compensation is provided only in circumstances consistent with principles of confidentiality and privacy regarding individual salary levels. Requests for such information should be directed to the relevant Dean or Vice President.
Policies and Procedures

SECTION: Financial
NO. 3.1.9.

CHAPTER: General
ISSUED: 12/2/92
REV. A
REV. B

POLICY: Fraud and Embezzlement

PURPOSE

The Creighton University Policy on Fraud and Embezzlement was written to clarify what constitutes fraud and embezzlement and to give University employees procedures to follow if they encounter what they believe is such unethical and illegal behavior.

POLICY

Any employee or any person contracted to perform work for Creighton University involved in fraud or embezzlement may be subject to a variety of disciplinary actions including, but not limited to, suspension, and termination. The offending employee or contractor may also be subject to criminal prosecution.

SCOPE

This policy applies to all University employees, contractors to, and employees of contractors to the University.

DEFINITIONS

Embezzlement: may be defined as any loss resulting from misappropriation of University assets.

Fraud: may be defined as the intentional misrepresentation or omission of facts for personal gain.

PROCEDURES

If fraud or embezzlement is known or suspected, contact the Director of Internal Audit or the General Counsel. An investigation will be conducted by the Internal Auditor in coordination with other campus officials as deemed appropriate. If the preliminary examination results in sufficient evidence of fraud or embezzlement, the President and appropriate Vice President will be notified. Appropriate actions will be taken by the individual's immediate supervisor in cooperation with the Vice President of the Division and the Director of Human Resources.
ADMINISTRATION AND INTERPRETATION

Questions regarding this policy may be addressed to the University's Human Resources Department and the Director of Human Resources. The University's Director of Internal Audit and the General Counsel are also important resources regarding the interpretation and administration of this policy.

AMENDMENTS OR TERMINATION OF THIS POLICY

Creighton University reserves the right to modify, amend, or terminate this policy at any time.
POLICY SUMMARY

This Policy applies to Creighton University Investigators/Support Personnel (as defined in the Policy) involved in research who have a Significant Financial Interest (as defined in this Policy) that may create a Financial Conflict of Interest.

Investigators/Support Personnel involved in a research project must complete a disclosure form and submit it to the Office of Research and Compliance annually. This form must also be completed and submitted to the Office of Research and Compliance within 30 days after an Investigator/Support Personnel obtains a new or additional Significant Financial Interest during the course of a project that is not included in their annual disclosure.

The Conflict of Interest Review Committee (CIRC) reviews the disclosure forms and decides whether a Financial Conflict of Interest exists. The CIRC prepares a resolution plan to manage, reduce, or eliminate any identified Financial Conflict of Interest. If the project involves human subjects research, the Institutional Review Board (IRB) may impose additional requirements before granting IRB approval.

Investigators/Support Personnel have the right to appeal the CIRC’s decision by requesting a reconsideration of their initial decision within 14 business days after notification of the decision. Failure to comply with this Policy will result in appropriate disciplinary action in accordance with applicable University policies.

PURPOSE

This Policy assures objectivity in research projects funded through Creighton University by all sources, including grants, contracts, or cooperative agreements. It ensures that the design, conduct, or reporting of research projects will not be biased by any conflicting interest of an Investigator/Support Personnel or his/her family members. This Policy also supports Creighton University’s institutional compliance with the Public Health Service regulations (42 CFR Part 50, Subpart F, and, as applicable, 45 CFR Part 94) and the grant requirements of the National Science Foundation.

POLICY

All Investigators/Support Personnel shall disclose all known Significant Financial Interests of the Investigator/Support Personnel and his/her family members.

In all cases, Financial Conflicts of Interest will be satisfactorily managed, reduced, or eliminated in accordance with this Policy.
SCOFFE

This Policy applies to all Investigators/Support Personnel.

This Policy also applies to subrecipients involved in research projects when the written agreement between Creighton University as the prime awardee and the subrecipient specifies that it will apply.

DEFINITIONS

Disclosure: An Investigator/Support Personnel’s statement to the University of any Significant Financial Interests.

Equity interest: Any stock, stock option, or other ownership interest.

Family member: Investigator’s/Support Personnel’s spouse or dependent children.

Financial Conflict of Interest (FCOI): A Significant Financial Interest that could directly and significantly affect the design, conduct, or reporting of research.

Institution of higher education: An educational institution in any state that:
- Admits as regular students only persons having a certificate of graduation from a school providing secondary education, or the recognized equivalent of such a certificate; or persons who have completed a secondary school education in a home school setting that is treated as a home school or private school under state law;
- Is legally authorized within such state to provide a program of education beyond secondary education;
- Provides an educational program for which the institution awards a bachelor’s degree or provides not less than a two-year program that is acceptable for full credit toward such a degree, or awards a degree that is acceptable for admission to a graduate or professional degree program, subject to review and approval by the Secretary of Health and Human Services;
- Is a public or other nonprofit institution; and
- Is accredited by a nationally recognized accrediting agency or association. If not so accredited, the institution must have been granted preaccreditation status by an agency or association recognized by the Secretary of Health and Human Services for the granting of preaccreditation status, and the Secretary has determined that the institution will meet the accreditation standards of the agency or association within a reasonable time.
**Policies and Procedures**

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**Institutional (professional) responsibilities:** An Investigator’s/Support Personnel’s responsibilities on behalf of the University, including:

- Research
- Research consultation
- Teaching
- Professional practice
- Consulting or other services to third parties related to Investigator’s/Support Personnel’s academic field and/or academic subject matter expertise
- Institutional committee memberships
- Service on panels, such as Institutional Review Boards or Data and Safety Monitoring Boards

**Investigator/Support Personnel:** The Principal Investigator, Project Director, co-Investigator, and any other person, regardless of title or position, involved in the design, conduct, or reporting of a research project.

**PHS awarding component(s):** The organizational unit(s) of the Public Health Service of the United States Department of Health and Human Services that funds the research project.

**Reimbursed travel:** Travel and related expenses (transportation, lodging, meals, incidentals) that are reimbursed to the PHS-funded Investigator/Support Personnel and are related to the Investigator’s/Support Personnel’s institutional (professional) responsibilities. This does **NOT** include travel that is reimbursed by:

- A Federal, state, or local government agency;
- An institution of higher education;
- An academic teaching hospital;
- A medical center; or
- A research institution that is affiliated with an institution of higher education.

**Related to the research:** When the CIRC determines that the Significant Financial Interest could be affected by the research or is in an entity whose financial interest could be affected by the research.

**Remuneration:** Salary and any payment for services not otherwise identified as salary (e.g., consulting fees, honoraria, paid authorship).

**Research:** A systematic investigation, study, or experiment designed to develop or contribute to generalizable knowledge, including, but not limited to, that relating broadly to public health, including behavioral and social sciences research. The term encompasses basic and applied research (e.g., a published article, book, or book chapter) and product development (e.g., a diagnostic test or drug). The term includes, but is not limited to, any such activity for which research funding is available from a PHS awarding component through a contract, whether authorized under the PHS Act or other statutory authority, such as a research grant, career development award, infrastructure award, institutional training grant, program project, or research resources award.
Significant Financial Interest: Anything of monetary value (whether or not that value is readily ascertainable) that reasonably appears to be related to the Investigator’s/Support Personnel’s institutional (professional) responsibilities and is received, obtained, or held directly or indirectly by the Investigator/Support Personnel and/or a family member, including one or more of the following interests:

- With regard to any **publicly traded entity**, a Significant Financial Interest exists if the value of any **remuneration** received from the entity in the 12 months preceding the disclosure and the value of any **equity interest** in the entity as of the date of disclosure, when aggregated, exceeds $5,000, as determined through reference to public prices or other reasonable measures of fair market value. (Note: $5,000 threshold for both remuneration and equity interests.)
- With regard to any **non-publicly traded entity**, a Significant Financial Interest exists if the value of any **remuneration** received from the entity in the 12 months preceding the disclosure, when aggregated, exceeds $5,000, or when the Investigator/Support Personnel and/or family member holds any **equity interest**. (Note: Remuneration has a $5,000 threshold, equity interests have a $0 threshold.)
- **Reimbursed or sponsored travel** in any amount (Note: $5,000 threshold), only if received by a PHS-funded Investigator/Support Personnel and, when aggregated per entity, exceeds $5,000

The term **Significant Financial Interest** does **NOT** include the following types of financial interests:

- Salary, royalties, or other remuneration paid by the University to the Investigator/Support Personnel;
- Income from investment vehicles, such as mutual funds and retirement accounts, as long as the Investigator/Support Personnel does not directly control the investment decisions made in these vehicles;
- Income from seminars, lectures, or teaching engagements sponsored by a Federal, State, or local government agency, an institution of higher education, an academic teaching hospital, a medical center, or a research institute that is affiliated with an institution of higher education; or
- Income from service on advisory committees or review panels for a Federal, State, or local government agency, an institution of higher education, an academic teaching hospital, a medical center, or a research institute that is affiliated with an institution of higher education.

**Sponsored travel**: Travel and related expenses (transportation, lodging, meals, incidentals, etc.) that are paid on behalf of the PHS-funded Investigator/Support Personnel and are not reimbursed to the Investigator/Support Personnel and are related to the Investigator’s/Support Personnel’s institutional (professional) responsibilities. This term does **NOT** include travel that is sponsored by:

- A Federal, state, or local government agency;
- An institution of higher education;
- An academic teaching hospital;
- A medical center; or
- A research institution that is affiliated with an institution of higher education.
Subrecipient: Subgrantees, contractors, collaborators, or subcontractors.

PROCEDURE

1. Disclosure of Significant Financial Interests

   a. Initial Disclosure of Significant Financial Interests to the Office of Research and Compliance


      ii. New Research Projects. If an annual disclosure form has not been submitted, all Investigators/Support Personnel shall complete and submit a disclosure form before any research project may be submitted to an external sponsor or for internal funding, as well as before all Institutional Review Board/Institutional Animal Care and Use Committee/Institutional Biosafety Committee applications are submitted.

      iii. Investigator/Support Personnel Added to an Existing Project. If an annual disclosure form has not been submitted, all Investigators/Support Personnel added to an existing research project shall complete and submit a disclosure form. No one shall be added to the project until the disclosure form has been reviewed pursuant to this Policy.

   b. New or Additional Financial Interests. Any Investigator/Support Personnel or his/her family member who discovers or acquires (e.g., through purchase, marriage, or inheritance) a new or additional Significant Financial Interest during the period of a research project must submit an updated disclosure form to the Office of Research and Compliance within 30 days of discovering or acquiring the new or additional Significant Financial Interest.

   c. Reimbursed Travel or Sponsored Travel. If not disclosed on the annual disclosure form, PHS-funded Investigators/Support Personnel shall disclose reimbursed or sponsored travel when aggregated per entity exceeds $5,000. When a disclosure includes a report of reimbursed travel or sponsored travel received by a PHS-funded Investigator/Support Personnel, the disclosure shall include:

      i. The purpose of the trip,

      ii. The identity of the sponsor/organizer,

      iii. The destination of the travel,

      iv. The duration of the travel, and

      v. The monetary value of the travel.
Sponsored travel does NOT include travel that is sponsored by:

i. A Federal, state, or local government agency;
ii. An institution of higher education;
iii. An academic teaching hospital;
iv. A medical center; or
v. A research institution that is affiliated with an institution of higher education.

d. **Additional Information.** Investigators/Support Personnel shall provide such additional information about disclosures as may be requested at any time by the Associate Vice President for Research and Compliance or his/her designee or the CIRC.

2. **Review Process**

a. **Initial Review by the Office of Research and Compliance:** The Associate Vice President for Research and Compliance, or his/her designee, will review each disclosure form to ensure that it has been properly filled out and signed by the Investigator/Support Personnel to determine the existence of any Significant Financial Interest.

   - If **NO Significant Financial Interest** is disclosed, the disclosure form is filed and no further action is required.

   - If a **Significant Financial Interest is disclosed**, the Office of Research and Compliance shall determine whether it is related to any grants or contracts, or to any open human, animal, or laboratory research. The nature of the study is reviewed relative to the Significant Financial Interest, and is then referred to the CIRC. The CIRC shall determine whether any Financial Conflict of Interest exists and, if so, how to manage, reduce, or eliminate the Financial Conflict of Interest before expenditure of project funds. No project funds shall be released until a final determination has been made.

b. **Conflict of Interest Review Committee Review Process.** The CIRC shall review (and, where necessary, investigate) all information contained in the disclosure to determine whether an Investigator/Support Personnel’s Significant Financial Interest is related to the research and, if so, whether it constitutes a Financial Conflict of Interest.
The following are possible determinations the CIRC may make regarding Financial Conflicts of Interest:

i. If it is determined that there is no Significant Financial Interest, the CIRC shall notify the Investigator/Support Personnel in writing, and this correspondence shall be included in the project file.

ii. If it is determined that there is a Significant Financial Interest, the CIRC shall determine whether any Financial Conflict of Interest exists and, if so, how to manage, reduce, or eliminate the Financial Conflict of Interest before expenditure of project funds, including developing and implementing a management plan and, if necessary a retrospective review and mitigation report.

Examples of conditions or restrictions that might be imposed in a management plan include, but are not limited to:

1. Public disclosure of Financial Conflicts of Interest (e.g., when presenting or publishing the research).
2. For research projects involving human subjects, disclosure of Financial Conflicts of Interest directly to participants.
3. Appointment of an independent monitor capable of taking measures to protect the design, conduct, and reporting of the research against bias resulting from the Financial Conflict of Interest.
4. Modification of the research plan.
5. Change of personnel or personnel responsibilities, or disqualification of personnel from participation in all or a portion of the research.
6. Reduction or elimination of the Significant Financial Interest (e.g., sale of an equity interest).
7. Severance of relationships that create financial conflicts.

### c. Review of Projects Involving Human Subjects Research

i. **Participation of an Investigator/Support Personnel with a Significant Financial Interest.** Any Significant Financial Interest(s) of Investigators/Support Personnel who are involved in human subjects research may present real or perceived risks to the welfare of human subjects and may require additional review. In most cases, an Investigator/Support Personnel may not participate in human subjects research while he/she has a Significant Financial Interest in the project or with the sponsor.
The CIRC may grant an exception on a case-by-case basis if the Investigator/Support Personnel provides compelling reasons to maintain the Significant Financial Interest and participate in human subjects research. These compelling circumstances or facts shall be consistent with the rights and welfare of human subjects. The CIRC shall establish written policies to require disclosure, monitoring, and implementation of any other measures it deems necessary in this circumstance.

ii. **Role of the University’s Institutional Review Board (IRB).** The IRB may accept or decline the CIRC’s determination and resolution. The IRB is ultimately responsible for protecting the rights and welfare of human subjects and, if it is not satisfied that the CIRC’s final determination will protect the rights and welfare of human subjects, it shall independently review the Significant Financial Interest and either refuse to approve the study or recommend to the CIRC its requirements to manage, reduce, or eliminate the Financial Conflict of Interest. The IRB has the final authority to determine whether any interest and its management allow the research to be approved.

d. **Intellectual Property Rights.** An Investigator/Support Personnel is **NOT** required to disclose as a Significant Financial Interest income (including royalties, license fees, or other forms of revenue) paid by the University to the Investigator/Support Personnel due to intellectual property rights assigned to the institution by the Investigator/Support Personnel and agreements to share in revenue related to such rights. However, Creighton University’s Intellectual Resource Management (IRM) Technology Transfer Office shall provide a report to the CIRC of any such intellectual property rights and agreements. The CIRC shall determine whether a Financial Conflict of Interest exists and whether a management plan is required. The involved Investigator/Support Personnel shall be required to comply with any such management plan, and the Financial Conflict of Interest identified shall be disclosed as required.

e. **New or Undisclosed Significant Financial Interests.** Whenever:

   i. an Investigator/Support Personnel new to a research project discloses a Significant Financial Interest,
   
   ii. an existing Investigator/Support Personnel discloses a new Significant Financial Interest, or
   
   iii. the University identifies a Significant Financial Interest that was not previously disclosed by an Investigator/Support Personnel or, for whatever reason, was not previously reviewed by the University during an ongoing research project (e.g., was not reviewed or reported by a subrecipient),
the CIRC shall, within 60 days:

i. Review the Significant Financial Interest,
ii. Determine whether it is related to the research,
iii. Determine whether a Financial Conflict of Interest exists, and, if so,
iv. Implement, on at least an interim basis, a management plan specifying the actions that have been and will be taken to manage such Financial Conflict of Interest going forward.

Depending on the nature of the Financial Conflict of Interest, the University may determine that additional interim measures are necessary regarding the Investigator’s/Support Personnel’s participation in the research project between the date that the Financial Conflict of Interest or the Investigator’s/Support Personnel’s noncompliance is determined and the completion of the University’s retrospective review.

3. Appeal Rights: If the Investigator/Support Personnel disagrees with a management plan developed by the CIRC, he/she may appeal the determination by submitting a written request and any supporting materials to the CIRC for reconsideration within 14 days after receiving notification of the management plan. The CIRC shall review the request and supporting materials and issue its final determination, which shall not be subject to further appeal. The Investigator/Support Personnel shall sign any management plan required by the CIRC before any funds may be expended.

4. Ongoing Monitoring: Whenever the University implements a management plan, the University, through the Research Compliance Quality Assurance Program and CIRC, shall monitor Investigator/Support Personnel compliance with the management plan on an ongoing basis until the research is completed.

5. Records Retention: The Office of Research and Compliance shall retain records of all disclosures and the University’s review of and response to each disclosure as follows:

a. PHS-Funded Projects: Three years after the date of submission of the final expenditures report or, where applicable, from other dates specific in 45 CFR 74.53 (b) for different situations.

b. NSF-Funded Projects: Three years beyond the termination or completion of the project, or until the resolution of any NSF action involving those records, whichever is longer.

c. All Other Externally or Internally Funded Projects: Three years after the termination or completion of the project.

6. Enforcement, Sanctions, and Noncompliance

a. General. Investigators/Support Personnel shall fully comply with this Policy. Examples of breaches of this Policy include, but are not limited to:
i. Failure to submit the disclosure form
ii. Intentionally filing an incomplete, erroneous, or misleading disclosure form
iii. Failing to provide any additional information requested by the Office of Research and Compliance or CIRC

Failure to comply with this Policy may result in disciplinary action, ranging from a public letter of reprimand to dismissal and termination of employment or affiliation with the University. Disciplinary action shall be consistent with and subject to the University’s progressive disciplinary policy or applicable sections of the Faculty Handbook.

b. PHS-Funded Projects

i. Retrospective Review: When a Financial Conflict of Interest is not identified or managed in a timely manner, the University shall, within 120 days of the University’s determination of noncompliance, complete a retrospective review of the Investigator’s/Support Personnel’s activities and the PHS-funded research project. This review shall determine whether there was any bias in the design, conduct, or reporting of the PHS-funded research, or any portion thereof, conducted during the time period of the noncompliance. The University shall document the retrospective review, including, but not limited to, all of the following key elements:
   1. Project number
   2. Project title
   3. Project Director/Principal Investigator (or contact Project Director/Principal Investigator, if a multiple Project Director/Principal Investigator model is used)
   4. Name of the Investigator/Support Personnel who has the Financial Conflict of Interest
   5. Name of the entity with which the Investigator/Support Personnel has a Financial Conflict of Interest
   6. Reason(s) for the retrospective review
   7. Detailed methodology used for the retrospective review (e.g., methodology of the review process, composition of the review panel, documents reviewed)
   8. Findings of the review
   9. Conclusions of the review

If an Investigator’s/Support Personnel’s failure to comply with this Policy or a management plan appears to have biased the design, conduct, or reporting of the PHS-funded research, the University shall promptly notify the PHS awarding component of the corrective action taken or to be taken.
ii. PHS Notification

1. Prior to the University’s expenditure of any funds under a PHS-funded research project, the University shall provide to the PHS awarding component a Financial Conflict of Interest report regarding any Investigator’s/Support Personnel’s Financial Conflict of Interest, and ensure that the University has implemented a management plan.

   In cases in which the University identifies a Financial Conflict of Interest and eliminates it prior to the expenditure of PHS-awarded funds, the University shall not submit a Financial Conflict of Interest report to the PHS awarding component.

2. For any Financial Conflict of Interest that the University identifies after its initial report during an ongoing PHS-funded research project (e.g., upon the participation of an Investigator/Support Personnel who is new to the research project), the University shall provide to the PHS awarding component, within 60 days, an updated Financial Conflict of Interest report regarding the conflict and ensure that the University has implemented a management plan.

3. **Mitigation Report:** If, after conducting a retrospective review, the University finds that it is warranted, it shall update the previously submitted Financial Conflict of Interest report, specifying the actions that will be taken to manage the Financial Conflict of Interest going forward. If bias is found, the University shall notify the PHS awarding component promptly and submit a mitigation report to the PHS awarding component. The mitigation report must include, at a minimum, the key elements documented in the retrospective review, as well as a description of the impact of the bias on the research project (e.g., extent of harm done, including any qualitative and quantitative data to support any actual or future harm; analysis of whether the research project is salvageable) and the University’s plan of action or actions taken to eliminate or mitigate the effect of the bias. Thereafter, the University shall submit Financial Conflict of Interest reports annually.

4. Any Financial Conflict of Interest report required under paragraphs (1) (2), or (3) above shall include sufficient information to enable the PHS awarding component to understand the nature and extent of the Financial Conflict of Interest, and to assess the appropriateness of the University’s management plan.
Elements of the Financial Conflict of Interest report shall include, but are not limited to, the following:

a. Project number
b. Name of the Investigator/Support Personnel who has the Financial Conflict of Interest
c. Name of the entity with which the Investigator/Support Personnel has a Financial Conflict of Interest
d. Nature of the financial interest (e.g., equity, consulting fee, travel reimbursement, honorarium)
e. Value of the financial interest (dollar ranges are permissible: $0–$4,999; $5,000–$9,999; $10,000–$19,999; amounts between $20,000–$100,000 by increments of $20,000; amounts above $100,000 by increments of $50,000), or a statement that the interest is one whose value cannot be readily determined through reference to public prices or other reasonable measures of fair market value
f. A description of how the financial interest relates to the PHS-funded research, and the basis for the University’s determination that the financial interest conflicts with the research
g. A description of the key elements of the University’s management plan, including:
   i. Role and principal duties of the conflicted Investigator/Support Personnel in the research project
   ii. Conditions of the management plan
   iii. How the management plan is designed to safeguard objectivity in the research project
   iv. Confirmation of the Investigator’s/Support Personnel’s agreement to the management plan
   v. How the management plan will be monitored to ensure Investigator/Support Personnel compliance
   vi. Other information as needed

5. For any Financial Conflict of Interest associated with an ongoing PHS-funded research project that was previously reported by the University, the University shall provide to the PHS awarding component an annual Financial Conflict of Interest report that addresses the status of the conflict and any changes to the management plan. These annual reports will be required for the duration of the PHS-funded research project, including extensions with or without funds.
### POLICY:

**Financial Conflict of Interest in Research**

The annual Financial Conflict of Interest report shall specify whether the Financial Conflict of Interest is still being managed, or explain why the Financial Conflict of Interest no longer exists.

6. In some cases, the Federal Department of Health and Human Services (HHS) may determine that a PHS-funded clinical research project whose purpose is to evaluate the safety or effectiveness of a drug, medical device, or treatment has been designed, conducted, or reported by an Investigator/Support Personnel with a Financial Conflict of Interest that was not managed or reported by the University as required. In these cases, the University shall require the Investigator/Support Personnel involved to disclose the Financial Conflict of Interest in each public presentation of the results of the research, and to request an addendum to previously published presentations.

   c. **NSF Notification**: The Associate Vice President for Research and Compliance shall keep the NSF Office of the General Counsel appropriately informed if Creighton University finds that it is unable to satisfactorily manage a Financial Conflict of Interest under an NSF-funded project.

   d. **Other Sponsors**: The Associate Vice President for Research and Compliance shall notify any other sponsor of Financial Conflicts of Interest and management plans imposed, as required by sponsor policy or contractual obligation.

7. **Other Requirements**

   a. **PHS Certification**: The appropriate University official shall certify on each PHS-funded proposal that the University:

      i. Has in effect an up-to-date, written, and enforced administrative process to identify and manage Financial Conflicts of Interest.

      ii. Shall promote and enforce Investigator/Support Personnel compliance with the requirements of 42 CFR Part 50, including those pertaining to disclosure of Significant Financial Interests.

      iii. Shall manage Financial Conflicts of Interest and provide initial and ongoing Financial Conflict of Interest reports to the PHS awarding component, consistent with 42 CFR Part 50.

      iv. Agrees to make information available to HHS, promptly upon request, relating to any Investigator/Support Personnel disclosure and the University’s review of and response to such disclosure, whether or not the disclosure results in the University’s determination of a Financial Conflict of Interest.

      v. Shall fully comply with the requirements of 42 CFR Part 50.
8. Public Accessibility

a. **Policy Availability.** The Office of Research and Compliance shall post and maintain this Policy on a publicly accessible Creighton University web site.

b. **Financial Conflict of Interest Public Accessibility Notice:** Within a reasonable time after determining an Investigator/Support Personnel has a Financial Conflict of Interest and, for PHS-funded research, prior to the University’s expenditure of any funds for that research, the Office of Research and Compliance shall ensure the public accessibility of information concerning any Financial Conflicts of Interest held by Investigators/Support Personnel participating in PHS-funded research. Response to all written requests for information shall be provided within five business days of receipt of the request. Written requests may be sent via email to COI@creighton.edu, or by mail to Office of Research and Compliance, 2500 California Plaza, Omaha, NE 68178. This information will also be available on the Office of Research and Compliance Conflict of Interest web site.

i. The information included in a response to a request for information shall include, at a minimum, the following:
   1. The Investigator’s/Support Personnel’s name
   2. The Investigator’s/Support Personnel’s title and role with respect to the research
   3. The name of the entity in which the Significant Financial Interest is held
   4. The name/title of the research project
   5. The nature of the Significant Financial Interest
   6. The approximate dollar value of the Significant Financial Interest (dollar ranges are permissible: $0–$4,999; $5,000–$9,999; $10,000–$19,999; amounts between $20,000–$100,000 by increments of $20,000; amounts above $100,000 by increments of $50,000), or a statement that the interest is one whose value cannot be readily determined through reference to public prices or other reasonable measures of fair market value

ii. The Office of Research and Compliance shall update the information annually.

iii. In addition, the Office of Research and Compliance shall update the information within 60 days of the University’s receipt or identification of information concerning any additional Financial Conflict of Interest of the Investigator/Support Personnel that was not previously disclosed, or upon the determination of Financial Conflict of Interest of Investigators/Support Personnel new to the research project.

iv. Information concerning the Financial Conflict of Interest of an individual shall remain available via written request for three years from the date that the information was most recently updated.
9. Education/Training

a. **Initial Training:** All current Investigators/Support Personnel shall be informed of and trained on this Policy, including the Investigator’s/Support Personnel’s responsibilities regarding disclosure of Significant Financial Interests, and the PHS Federal regulations on Financial Conflict of Interest. All Investigators/Support Personnel must complete initial Financial Conflict of Interest training before beginning work on any research project.

b. **Training Updates:** Investigators/Support Personnel shall complete re-training on Financial Conflict of Interest every four years after initial training, or more often when any of the following circumstances apply:
   i. The University revises its Financial Conflict of Interest policies or procedures in any manner that affects the requirements of Investigators/Support Personnel.
   ii. The University finds that an Investigator/Support Personnel is not in compliance with this Policy or a management plan.

c. **Office of Research and Compliance Services.** The Office of Research and Compliance shall provide and/or arrange for and track required training. Training can be via live presentation or CITI or any successor educational service.

10. Federally Funded Subcontracts

If the University carries out Federally funded research through a subrecipient, the University shall take reasonable steps to ensure that any subrecipient Investigator/Support Personnel complies with Federal requirements for Financial Conflicts of Interest by:

a. Incorporating as part of the written agreement with the subrecipient terms that require the subrecipient to:
   i. apply its Financial Conflict of Interest policy to its Investigators/Support Personnel;
   ii. certify that its policy complies with applicable Federal regulations; and
   iii. agree to report all identified Financial Conflicts of Interest to the University within a certain time period. Such time period(s) shall be sufficient to enable the University to provide timely Financial Conflict of Interest reports, as necessary, to the Federal agency.

b. Providing Financial Conflict of Interest reports to the Federal agency regarding all Financial Conflicts of Interest of all subrecipient Investigators/Support Personnel (i.e., prior to the expenditure of any funds and within 60 days of any subsequently identified Financial Conflict of Interest).
If the subrecipient does not have a Financial Conflict of Interest policy or refuses to apply the policy or certify compliance of the policy with Federal regulations, the agreement with the subrecipient shall:

a. require the subrecipient’s Investigators/Support Personnel to comply with this Policy, and

b. specify time period(s) for the subrecipient to submit all Investigator/Support Personnel disclosures of Significant Financial Interests to the University. Such time period(s) shall be sufficient to enable the University to comply with its review, management, and reporting obligations.

Disclosures submitted by subrecipients shall be reviewed by the CIRC, and any Financial Conflicts of Interest shall be managed and monitored as set forth in this Policy.

ADMINISTRATION AND INTERPRETATION

Questions regarding this Policy may be directed to the Office of Research and Compliance or the Office of General Counsel at the University.

AMENDMENTS OR TERMINATION OF THIS POLICY

Creighton University reserves the right to modify, amend, or terminate this Policy at any time. Nothing in this Policy should be construed as a contract between the University and its employees.
DISCLOSURE OF FINANCIAL RELATIONSHIP
FOR SPONSORED PROJECTS
(08/24/2012—8/23/2013)

Name (Print): ___________________________________________________ Date: ________________________________
Department: ____________________________________________________ Phone: _______________________________
E-mail Address: ______________________________________________________________________________________

Please check appropriate boxes:

☐ Initial Disclosure ☐ Annual Disclosure ☐ Update
☐ Investigator ☐ Co-Investigator ☐ Support Personnel
☐ Committee Member ☐ PHS-funded ☐ Student

This Form shall be completed by all Investigators/Support Personnel/Research Committee Members pursuant to University
Policy 3.1.10, Financial Conflict of Interest in Research.

Section A. Financial Interests/Relationships

Report all financial interests/relationships currently held, or held within the past 12 months (or during the previous calendar
year for annual disclosures), unless otherwise stated, indicating the amount of the financial interest/relationship and the entity
or organization. This form must be updated with 30 days of acquiring any new or additional financial interests/relationships.

1. For Publicly Traded Entities: Payment for Services (Remuneration) and/or Equity (Ownership) Interests.
   Have you and/or your spouse or dependents received or will you and/or your spouse or dependents receive any salaries and/or
   other payments (e.g., consulting fees; honoraria, study design; management position, independent contractor, service on
   advisory committees or review panels of for-profit entities, board membership of for-profit entities; seminars, lectures or
   teaching engagements for for-profit entities; any interest that could be affected by the outcome of the research) from any one
   entity or group of related entities, or do you and/or your spouse or dependents hold any equity interests or ownership interest
   (e.g., stock, stock options, partnership) that when totaled together for any entity or group of related entities exceeded $5,000 in
   value during the previous 12 months or that currently as of the date of this disclosure exceed $5,000? NOTE: Equity interests
   exclude interests in diversified mutual funds, unless you or your spouse/dependents have the ability to directly control the
direction of the investments.

   If Yes, note exact amount with explanation of source(s):
   _____________________________________________________________________________________________
   _____________________________________________________________________________________________

2. For Non-publicly Traded Entities: Payment for Services (Remuneration). Have you and/or your spouse or
dependents received or will you and/or your spouse or dependents receive any salaries and/or other payments (e.g., consulting
fees; honoraria, study design; management position, independent contractor, service on advisory committees or review panels
of for-profit entities, board membership of for-profit entities; seminars, lectures or teaching engagements for for-profit entities;
any interest that could be affected by the outcome of the research) from any one entity or group of related entities, that when
totaled together for any entity or group of related entities exceeded $5,000 in value during the previous 12 months or that
currently as of the date of this disclosure exceed $5,000?

   If Yes, note exact amount with explanation of source(s):
   _______________________________________________________
   _______________________________________________________

   ☐ Yes ☐ No
3. **For Non-publicly Traded Entities: Equity (Ownership) Interests.** Do you and/or your spouse or dependents hold any equity interests or ownership interests (e.g., stock, stock options, partnership) in non-publicly traded entities? **NOTE:** The threshold for equity (ownership) interests is $0; you must report all such interests here. **NOTE:** Equity interests exclude interests in diversified mutual funds, unless you or your spouse/dependents have the ability to directly control the direction of the investments.

If Yes, note exact amount with explanation of source(s):

☐ Yes  ☐ No

4. **Reimbursed Travel (for Investigators/Support Personnel involved in PHS-funded projects):** Have you and/or your spouse or dependents received or will you and/or your spouse or dependents receive reimbursement of $5,000 or more (aggregated per entity) for travel and related expenses (e.g., transportation, lodging, meals, incidentals) that are related to your institutional (professional) responsibilities? **NOTE:** This does not include travel that is reimbursed by a Federal, state, or local government agency; an institution of higher education; an academic teaching hospital; a medical center; or a research institution that is affiliated with an institution of higher education.

If Yes, note the following:
- The purpose of the trip:
- The identity of the sponsor/organizer:
- The destination of the travel:
- The duration of the travel:
- The monetary value of the travel:

☐ Yes  ☐ No

5. **Sponsored Travel (for Investigators/Support Personnel involved in PHS-funded projects):** Have you and/or your spouse or dependents received or had travel and related expenses (e.g., transportation, lodging, meals, incidentals) of $5,000 or more (aggregated per entity) paid on your behalf (i.e., are not reimbursed) that are related to your institutional (professional) responsibilities? **NOTE:** This does not include travel that is sponsored by a Federal, state, or local government agency; an institution of higher education; an academic teaching hospital; a medical center; or a research institution that is affiliated with an institution of higher education.

If Yes, note the following:
- The purpose of the trip:
- The identity of the sponsor/organizer:
- The destination of the travel:
- The duration of the travel:
- The monetary value of the travel:

☐ Yes  ☐ No

6. **Contingent Compensation.** Have you and/or your spouse or dependents received or will you and/or your spouse or dependents receive any compensation that will be contingent on the outcome of the research?

If Yes, note exact amount with explanation of source:

☐ Yes  ☐ No

7. **Other Financial Interests or Relationships.** Have you and/or your spouse or dependents received any loans, payments, gifts, in-kind contributions or similar financial interests or relationships that are in any way related to your institutional (professional) responsibilities?

If Yes, note exact amount with explanation of source:

☐ Yes  ☐ No
8. **Incentives.** If involved in any research activity, will you receive any money, gift, or anything of monetary value above and beyond the actual costs of enrollment, conduct of the research, and reporting on the results, including, but not limited to, finders fees, referral fees, recruitment bonuses, an enrollment bonus for reaching an accrual goal or similar types of payments?

If Yes, note exact amount with explanation of source:

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<th>Yes</th>
<th>No</th>
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</table>

9. **Intellectual Property or Proprietary Interests.** Do you and/or your spouse or dependents have any intellectual property or proprietary interests related to your institutional (professional) responsibilities, including, but not limited to, a patent, trademark, copyright, licensing agreement, or royalties, licensing fees, or other monies related to the intellectual property or proprietary interest not paid through the University?

If Yes, note exact amount with explanation of source:

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<th>Yes</th>
<th>No</th>
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</table>

10. **Other.** Do you and/or your spouse or dependents have any other interests or relationships (including volunteer services) that might constitute a conflict of interest or an appearance of conflict of interest in connection with the research project?

If Yes, note exact amount with explanation of source:

<table>
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<th>Yes</th>
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**Section B. Attestation**

I affirm that I:

Have read the University Policy 3.1.10, Financial Conflict of Interest in Research, and agree to abide by its terms.

Will update this Disclosure Form on an annual basis or as any new reportable significant financial interest arises.

Will comply with any resolution plan proposed by the CIRC (and/or IRB, if the project involves human subjects) to manage, reduce or eliminate any actual or potential financial conflict of interest before conducting any research where a conflict of interest has been identified by the CIRC.

Understand that, if I am a PHS-funded Investigator/Support Personnel, information on all financial conflicts of interest will be made publicly accessible.

Understand and agree that if I submit this electronically with a typed signature, this will be considered my legally binding signature.

Signed: _______________________________   Dated: _______________________________

➢ Submit the completed form and send a signed PDF copy OR a copy with a typed signature via email to

COI@creighton.edu

OR mail a signed paper copy to:

Sara Coolman, Associate Director for Research and Compliance  
Research Compliance Office, CRISS I, Room 109
I. PURPOSE

The purpose of this policy is to protect the best interests of Creighton University when entering into any transactions by ensuring that such transactions will not be adversely affected by the conflicting interests of those the University employees responsible for the transaction.

II. POLICY

It is the policy of the University that all employees must carry out their responsibilities to the University in the best interests of the University.

Further, all employees must disclose to the University any potential conflicting interests.

III. DEFINITIONS

A. Conflicting Interest: A potential or actual conflict of interest exists when commitments and obligations to the University are likely to be compromised by a person’s other interests or commitments, especially financial. This includes:

1. An existing or potential financial interest which may affect or appear to affect the individual’s independent judgment while performing his/her duties for the University.

2. An existing or potential non-financial interest which may affect or appear to affect the individual’s independent judgment while performing his/her duties for the University.

3. Receiving or the possibility of receiving a material, financial or other benefit from knowledge of confidential or proprietary University information.

B. Employee: Includes full and part time employees, staff and faculty.

C. In addition, a conflict may occur if situations 1-3 above exist concerning a member of the immediate family of the employee (spouse, child, parent, or parent-in-law).

IV. PROCEDURE

A. University employees must carry out their duties and responsibilities to the University in a manner which is both loyal to the best interests of the University and avoids the appearance or actual presence of a conflict of interest.
Policies and Procedures

SECTION: Financial

CHAPTER: General

POLICY: Conflict of Interest Policy for All Employees

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<th>ISSUED: 8/23/00</th>
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B. Where an employee reasonably believes that a conflict of interest may exist or appear to exist, the employee must promptly and fully disclose the conflict to his/her next higher administrator in the employee's supervisory line who is at least at the level of departmental director or chair, refrain from participation in the matter until the question is resolved, and follow any directions given by the University concerning the matter.

C. An administrator who receives a disclosure shall:

1. Review the conflict or potential conflict with the employee;
2. Determine whether the administrator's supervisor should review the gathered information on the conflict or potential conflict;
3. Recommend and initiate actions to manage, reduce, or eliminate the conflict; and
4. Report annually to his/her Vice President how any significant conflicts of interest have been resolved.

D. Where a supervisor is asked to address a potential conflict of interest, any such potential conflict which cannot be reasonably resolved or eliminated shall be reviewed with the assistance of the General Counsel.

E. Where the potential conflict of interest affects a proposed or ongoing research project which has an external sponsor, such conflict of interest must be disclosed and addressed pursuant to the University’s Financial Conflict of Interest Policy Pertaining to Externally-Sponsored Projects, which is a separate and independent conflict of interest policy requiring separate compliance.

F. Violations of this policy may lead to disciplinary action including written warning, suspension or termination.
I. PURPOSE

The purpose of this policy is to protect the best interests of Creighton University when it is contemplating entering into a transaction or arrangement that might benefit the private interest of a Senior Administrator by ensuring that such transactions will not be adversely affected by conflicts of interest, to ensure Senior Administrators act in the best interests of the University and to ensure the University operates in a manner consistent with its tax exempt status.

II. POLICY

It is the policy of the University that all Senior Administrators must carry out their responsibilities to the University in the best interests of the University. Further, Senior Administrators should, when acting on behalf of the University, act at all times in a manner which avoids even the appearance of a conflict of interest unless and until disclosure of the conflict is made and a disposition determined in accord with Articles IV. B and C, respectively.

All Senior Administrators must disclose to the University, at least on an annual basis, any financial interest of the Senior Administrator or a Family Member that may result in an actual or potential conflict of interest. In addition, the Internal Revenue Service (IRS) requires annual disclosures of certain business and family relationships on the part of Senior Administrators. (See Schedule A of the Conflict of Interest and Disclosure Policy Annual Statement of Disclosure.) This policy is intended to supplement, but does not replace, any applicable state and federal laws governing conflict of interest applicable to non-profit and charitable organizations.

III. DEFINITIONS

A. Conflict of Interest: A conflict of interest exists when a Senior Administrator’s commitment and obligation to the University may be compromised by the Senior Administrator’s other interests or commitments, especially financial interests. A conflict of interest may exist when a Senior Administrator or a Family Member of the Senior Administrator has a financial interest, directly or indirectly, through business, investment or otherwise in one of the following:

1. An existing or potential ownership or investment interest in any entity with which the University has a transaction or arrangement. An ownership or investment interest may be through equity, debt, or other means.

2. An existing or potential compensation arrangement with any entity or individual with which or with whom the University has a transaction or arrangement. Compensation includes any direct or indirect payment in cash or in kind, including gifts or favors that are substantial in nature (more than $100) or forgiveness of debt.
3. An existing or potential ownership or investment interest in, or compensation arrangement with, an entity or individual with which or with whom the University is negotiating a transaction or arrangement.

4. A position which involves a management function (director, officer, trustee, partner, or manager) for another entity or individual with which or with whom the University is negotiating a transaction or arrangement or has an existing transaction or arrangement.

B. Senior Administrators: President, Senior Vice President for Operations, Vice Presidents, Deans.

C. Family Member: Spouse, children, siblings, parents, grandparents, grandchildren or spouses of all listed.

IV. PROCEDURE

A. Senior Administrators of the University are required to make an annual disclosure (see attached) to the President of the University of any financial interests of the Senior Administrator or any Family Member that may result in a potential or actual Conflict of Interest as set out above. In addition, Senior Administrators will annually respond to IRS required inquiries as requested in the attached Conflict of Interest and Disclosure Policy Annual Statement of Disclosure. Annual disclosures are required to be made as of July 1ST of each fiscal year and filed by July 15th of each year.

B. A Senior Administrator is also responsible for providing written notification to the President of any instances of any financial interest that may result in a potential or actual Conflict of Interest required to be disclosed under this Policy which arises in the interim period between annual disclosure statements.

A. The President or (Board Chair, for the President) shall first review the annual and any interim disclosure statements of each Senior Administrator.

1. The President or Board Chair shall determine whether a Conflict of Interest exists and, if so, what action should be taken by the University to manage, reduce, or eliminate the conflict. Not all transactions in which a potential conflict exists are impermissible. Permitted transactions must be in the University's best interests, for the University's benefit and fair and reasonable to the University. Each person to whom financial interests are reported is encouraged to consult with University General Counsel in making his/her determination in less than clear cases. The President or Board Chair may request, and an affected Senior Administrator shall provide upon request, such additional information as may be necessary to make a determination of and resolve any potential or actual Conflict of Interest.
2. The President must report any potential or actual Conflict of Interest to the Chair of the University’s Board of Directors.

3. The President will forward copies of the annual disclosure statements to the Vice President for Finance for use in preparing the University’s annual information return.

D. If in the course of his or her duties, a Senior Administrator becomes aware of a business, investment or other potentially valuable opportunity that rightfully belongs to the University and not to the Senior Administrator or another entity with which the Senior Administrator is affiliated, the Senior Administrator shall bring the opportunity to the attention of the President.

E. Senior Administrators may not use or disclose confidential information, whether of the University or a third party, acquired as a result of service to the University for any purpose unrelated to University business, or provide such information to any third party without the consent of the President. Wrongful use or disclosure of confidential information includes, but is not limited to, use or disclosure of information to engage, invest or otherwise participate in any business, project, venture, or transaction other than through the University.

F. Violations of this policy may lead to disciplinary action including written warning, suspension or termination.

SCOPE

This policy applies to Senior Administrators as defined in this Policy.

ADMINISTRATION AND INTERPRETATIONS

Specific questions regarding potential or actual Conflicts of Interest should be directed to the Office of General Counsel.

AMENDMENTS OR TERMINATION OF POLICY

The University reserves the right to modify, amend or terminate this policy at any time.
I acknowledge that I have read and understand Creighton University's Conflict of Interest and Disclosure Policy for Senior Administrators attached to this Statement. Further, I declare to the President that neither I nor any family member* have any potential or actual conflicts of interest which could be perceived as adversely affecting the performance of my University duties or responsibilities or which could be perceived as affecting my independence of judgment with respect to transactions between the University and the other business enterprise except as described below.

I also acknowledge that:

- the University did not provide any grants or assistance to me or any member of my family except as disclosed on the attached Schedule A, Section 1.
- I have disclosed all business transactions between the University and me or any member of my family on Schedule A, Section 2;
- I have disclosed all family relationships on Schedule A, Section 3, if applicable, with any individuals listed on Schedule B; and
- I have disclosed all business relationships on Schedule A, Section 3, if applicable, with any of the persons listed on Schedule B.

I understand that the University will rely on this information to file its annual information return, Form 990, with the Internal Revenue Service. I agree that I will provide an updated form to the University President whenever a material change occurs in the information I have provided.

Dated this ______ day of ____________________, 20___.

________________________________________
Signature

* Includes spouse, children, siblings, parents, grandparents, grandchildren or spouses of all listed.
1. Were any grants or assistance (i.e. scholarships, fellowships, internships, prizes or awards, including the provision of goods or services or use of facilities) provided by the University to you or your family members during the year?

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<thead>
<tr>
<th>Recipient</th>
<th>Type of payment or Assistance</th>
<th>Relationship</th>
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2. Were there any business transactions made during the tax year between the University and you or your family members that exceed the reporting thresholds? The reporting threshold is all payments during the year that exceed $100,000 or compensation to a family member that exceeds $10,000 (compensation can be either as an employee of Creighton University or an independent contractor).

<table>
<thead>
<tr>
<th>Entity Name</th>
<th>Relationship</th>
<th>Amount of Transaction</th>
<th>Description</th>
<th>Revenue Share, Yes or No</th>
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3. Please use the attached list of Officers, Trustees, and Key Employees who will be reported in Part VII, Section A of the Form 990 to respond to the following two questions:

   a) Do you or a family member have a family relationship with any of the persons on the attached list?
      Yes  No

<table>
<thead>
<tr>
<th>Individual Name</th>
<th>Family Relationship</th>
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   b) Do you or a family member have a business relationship with any of the persons on the attached list? This excludes transactions in the ordinary course of either party’s business on the same terms as are generally offered to the public.

      Yes  No

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<tr>
<th>Individual Name</th>
<th>Business Relationship</th>
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</table>
**Policies and Procedures**

**SECTION:** Financial  
**NO.:** 3.1.13.

**CHAPTER:** General  
**ISSUED:** 9/20/06  
**REV. A**  
**REV. B**  
**REV. C**

**POLICY:** External Auditor Independence  
**PAGE 1 OF 1**

**PURPOSE**

Creighton University recognizes that independence (both actual and perceived) of the public accounting firm conducting the external audit of the University’s annual financial statements is necessary to assure a valid external audit.

**POLICY /PROCEDURES**

In order to assure independence of the University external auditors, the public accounting firm conducting the University’s annual external audit is prohibited from providing certain non-audit services to the University. Examples of prohibited non-auditing services are as follows:

- Bookkeeping or other services related to the accounting records or financial statements;
- Financial system design and implementation;
- Appraisal or valuation services, fairness opinions, or contribution-in-kind reports;
- Actuarial services;
- Internal auditing outsourcing services;
- Management or human resource functions;
- Broker or dealer, investment advisor, or investment banking services;
- Legal services or expert services unrelated to the audit;

An exception to this policy may be made only when there are extenuating circumstances and only upon the advance approval of the Senior Vice President for Operations and the University Audit Committee.

**SCOPE**

This policy applies to all organizations and divisions within the Creighton University corporate structure.

**AMENDMENTS AND TERMINATION OF THIS POLICY**

The University reserves the right to modify, amend or terminate this policy at any time.
Purposes and Procedures

**SECTION:** Financial

**CHAPTER:** General

**POLICY:** Independent External Audits

**PURPOSE**

To assure the accuracy of the Creighton University’s annual financial reports and enhance internal controls, the University will engage an external audit firm to perform an audit of the year-end financial reports. Consistent with best practices related to the independence and effectiveness of external auditors, the University requires that the external audit firm report directly to the Audit Committee of the Board of Directors.

**POLICY /PROCEDURES**

1. An audit of the University financial statements is required annually.
2. The external audit firm must be approved by the Audit Committee.
3. The audit engagement letter must be signed by the University’s Chief Financial Officer and the Audit Committee.
4. All services provided to the University by the external audit firm must be approved in advance by the Audit Committee.
5. The performance of the external audit firm must be evaluated by the Audit Committee. This evaluation should include consideration of the timeliness of the services and deliverables, accuracy of the audit and value for the cost of the services.
6. The external audit firm must discuss with the Audit Committee any material issues related to deficiencies in University internal control, any issues related to fraud or embezzlement, or any material issues related to questionable accounting practices discovered during the audit.
7. The external audit firm must present the summary schedule of unadjusted differences discovered during the audit to the Audit Committee.
8. The lead engagement partner of the external audit firm must rotate off the University engagement at least every seven years, with a timeout of 2 years.

**SCOPE**

This policy applies to all organizations and divisions within the Creighton University corporate structure.

**AMENDMENTS AND TERMINATION OF THIS POLICY**

The University reserves the right to modify, amend or terminate this policy at any time.
Policies and Procedures

SECTION:
Financial

CHAPTER:
General

POLICY:
University Employment of Former External Audit Firm Employees

PURPOSE

Consistent with best practices related to the independence and effectiveness of external audits, Creighton University requires a careful consideration of the benefits and risks of employing a Chief Financial Officer (CFO) or controller who has worked for the University’s current external audit firm within the preceding year, and consider how the position may affect the University’s external audit.

POLICY /PROCEDURES

In order to assure independence (both perceived and actual) of the University external auditors, any decision to hire a CFO or controller who was employed by the University’s external auditors within the preceding year must be weighed as to the associated benefits and risks.

Potential benefits to be considered:
- The individual’s familiarity with University financial environment and practices.
- The individual’s training and familiarity with generally accepted accounting principles and other accounting rules and standards.

Potential risks to be considered:
- Possible allegiances (or alienation) between the employee and the external audit firm management.
- Possible bias in selecting future external audit firms.
- Actual or perceived conflict of interest.

In all cases, approval of the Audit Committee is required prior to hiring a CFO/controller who has worked for the University’s external audit firm within the preceding year.

SCOPE

This policy applies to all organizations and divisions within the Creighton University corporate structure.

AMENDMENTS AND TERMINATION OF THIS POLICY

The University reserves the right to modify, amend or terminate this policy at any time.
PURPOSE

Creighton University is committed to high ethical standards in financial practices for all employees, students and parties with whom the University conducts business. The University believes that good faith reporting of suspected or known financial misconduct is the responsibility of all faculty, staff, students and contractors with whom the University conducts business.

EXCEPTIONS TO THIS POLICY

This policy is not intended to address noncompliant activity that may lead to fraud, waste or abuse in the University’s delivery of health care services. Persons having such concerns are directed to policy 2.1.21. “False Claims Laws and Employee Reporting of Noncompliance” and the University’s Compliance Plan for Health Sciences Billing and Patient Services, accessible at: http://www.creighton.edu/fileadmin/user/BillingCompliance/docs/Compliance_Plan_for_Health_Sciences.pdf

This policy is not intended to address the reporting of noncompliant conduct in research or sponsored programs, nor is it intended to address suspected research misconduct. Persons having such concerns are directed to Policy 2.1.19. “Reporting of Noncompliant Conduct in Research or Sponsored Programs” and Policy 4.2.2. “Research Misconduct” for appropriate reporting mechanisms.

For purposes of this policy, the areas not addressed by this policy are referred to as the “Listed Exclusions.”

This policy may be administered in conjunction with Policy 3.1.9. “Fraud and Embezzlement,” when appropriate.

DEFINITIONS

Financial misconduct includes, but is not limited to:

- Misrepresenting financial facts or information, or withholding financial information that could have a material effect on financial reporting, in areas other than those addressed by Listed Exclusions;
- Forgery or alteration of documents with the intent to mislead, in areas other than those addressed by Listed Exclusions;
- Noncompliance with regulatory requirements governing University transactions, in areas other than those addressed by Listed Exclusions;
- Unauthorized disclosure of confidential information, (employee, donor, vendor, etc.)
- Deliberate circumvention of University internal control processes, in areas other than those addressed by Listed Exclusions;
Policies and Procedures

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POLICY: Reporting Financial Misconduct

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- Unauthorized alteration, access or manipulation of electronic files, except as may be more specifically addressed in Policy 2.4.25. “Fair, Responsible and Acceptable Use;”
- Misappropriation or misuse of University resources, including funds, supplies, equipment, electronic data or other assets;
- Authorizing or receiving reimbursement or compensation for goods not received, hours not worked or services not performed;
- Failure to report or attempts to conceal the improper financial conduct of others;
- Discouraging or preventing the reporting of improper financial conduct by others.

POLICY/PROCEDURES

Financial misconduct known or suspected by any employee, student or contractor with whom the University conducts business is to be reported using the following reporting progression:

1. Discuss the financial misconduct with your supervisor. If this does not resolve the issue, or you are not comfortable discussing the issue with your supervisor, proceed to the next reporting level.
2. Discuss the financial misconduct with higher level management. If this does not resolve the issue, or you are not comfortable discussing the issue with higher level management, proceed to the next reporting level.
3. Discuss the financial misconduct with the Internal Audit Department or University General Counsel.

Any person who is unsure of where to report suspected financial misconduct or activities that may be addressed by other University policies may consult informally with the Internal Audit Department or University General Counsel as to their reporting options.

No person shall be retaliated against for making a good faith report of known or suspected financial misconduct (see Policy 2.2.24. Whistleblower Protection). Failure to report known financial conduct is considered to be a violation of this policy. However, if after investigating any report of financial misconduct, the University determines that the report was frivolous, was not made in good faith or that the reporter provided false information, disciplinary action may be taken against the individual who filed the report or gave false information. Such disciplinary action may include sanctions up to and including termination of employment or enrollment, or termination of the individual’s business affiliation with Creighton.

SCOPE

This policy applies to all University students, faculty and staff, and all contractors with whom the University conducts business.

AMENDMENTS AND TERMINATION OF THIS POLICY

The University reserves the right to modify, amend or terminate this policy at any time.
PURPOSE

To provide guidance for the acquisition, use, disposal and recordkeeping of gifts of tangible property (excluding real estate) and securities. Please refer to Policy 3.1.2 for direction regarding Real Estate Gifts.

POLICY

Creighton University may accept contributions of goods that can be used to advance the mission of Creighton and/or any of its affiliates, or that may be converted into cash. Prior to accepting any Gifts-In-Kind ("GIK"), University personnel must consult with the Office of Development in University Relations. Acceptance of a GIK with a fair market or appraised value of $5,000 or more requires the approval of the Senior Associate Vice President of Development and Campaign Director, the Associate Vice President for Finance ("Associate VP Finance") and/or the General Counsel.

The University cannot offer tax advice or determine the value of the contribution. It is the responsibility of the donor to substantiate to the IRS the gift value for tax purposes. The University reserves the right to evaluate the reported valuation for reasonableness for gift recognition purposes.

The IRS requires a donor to submit IRS Form 8283 for GIK donations with an estimated value of $5,000 or more. A donor may request the University complete IRS Form 8283 Part IV, which must be signed by the Associate VP Finance. The University signature is not required on Form 8283 for gifts of securities.

Gifts-In-Kind, Tangible Property, Valued at or above $5,000
Before accepting a GIK with an estimated value of $5,000 or more, a Development Officer or other University employee who is aware of the potential GIK must obtain approval from the Senior Associate Vice President of Development and Campaign Director, the Associate VP Finance and, if necessary, the General Counsel. In certain cases, the University may not be able to accept the offer of a GIK if the item is deemed to be illiquid or incompatible with the University’s mission.

The Office of Advancement Services in University Relations will issue the University’s official receipt to the donor. In compliance with IRS regulations, the receipt will contain a description of the contribution and will not include a statement as to the monetary value of the contribution. It will further contain a statement as to what, if any, goods were given in exchange for the contribution.

If the GIK is from an individual, the IRS requires the donor to provide an appraisal prepared by a qualified appraiser to substantiate his/her charitable tax deduction. Refer to the section “Qualified Appraisal Requirements” in the IRS Code for details. The cost of the appraisal is the responsibility of the donor.
The appraiser completes Section IV of IRS Form 8283 and the donor completes Line 5, Columns (a) and (b) and Part II if applicable; Part IV will be signed by the Associate VP Finance.

If the University has signed an IRS Form 8283 and then sells, exchanges or otherwise transfers the GIK within three years from the date of gift, the University must, in most circumstances, file a donee information return (IRS Form 8282) within 125 days of disposing of the property. If the University donates the item to another charity, Form 8282 also has to be completed with 125 days of disposition.

The Office of the Associate VP Finance is responsible for the disposition of all GIK’s and the completion of Form 8282.

The University also will advise the donor if such a transaction occurs as it may affect the charitable tax deduction for which the donor qualifies. A Development Officer will coordinate any subsequent communication to the donor.

Qualified Appraisal Requirements

1. Appraiser must hold himself or herself out to the public as an appraiser and state credentials showing that he or she is qualified to appraise the type of property being valued.
2. Appraiser must value the property no more than 60 days before the date of gift.
3. Appraiser cannot be the donor or employed by the University or its affiliates.

The appraisal must contain the following information:

1. A description of the item
2. Statement of its physical condition
3. The date (or expected date) of the contribution
4. Name, address and tax ID number of the appraiser
5. Qualifications of the appraiser including his/her background, experience and education
6. Statement that the appraisal was prepared for income tax purposes
7. Date the item was valued
8. Appraised fair market value of the item
9. Method of valuation (income approach; market data approach; replacement cost minus depreciation approach.)
Securities
Donors wishing to make a gift of securities should contact the Office of Development in University Relations for guidance on transferring securities to the University’s brokerage firms.

Gifts of security are recorded for recognition purposes at the mean of the high and low price per share on the date the security reached the University’s brokerage account.

Gifts in Kind Disposition

At the end of each fiscal year, the Associate VP Finance will prepare a written review of all GIKs held by the University and will update disposition intentions and estimated Fair Market Value (FMV) as appropriate.

Upon completion of GIK disposition, the Associate VP Finance will provide pertinent transaction documentation to the Controller’s Office and to Advancement Services in University Relations. If the GIK was provided in support of an endowment, the value of the GIK reflected in the endowment will be adjusted to match the cash proceeds received by the University from the disposition.

Conflict Resolution

The Gift Exception and Oversight Committee is comprised of the Controller and/or the Associate VP Finance, a member of the University's Board of Directors appointed by the President, and the University Relations Senior Director of Advancement Services.

This Committee will be convened to review and resolve any disputes related to the acceptance, accounting, recording and stewardship related to GIK donations.

Disputes related to gift receipt for tax purposes, IRS filings or other legal matters will be addressed by the Associate VP Finance in collaboration with the Vice President for Finance and University General Counsel.

Exclusions

Contributed Services
Contributed services cannot be counted as a gift and do not qualify as a charitable tax deduction to the donor. However, a donor of services may be able to deduct expenses incurred while performing these services. In such cases, the donor should consult with a tax accountant. The University will not issue a receipt for contributed services. For donor recognition purposes, University Relations may decide to record these items at the FMV.
Materials
Materials created by the donor are limited to a tax deduction amount equal to the cost of the materials used to create the piece. For donor recognition purposes, University Relations may decide to record these items at the FMV, but a receipt will not be issued.

Real Estate
Please refer to Policy 3.1.2 for direction on Real Estate Gifts.

SCOPE
This policy applies to Gift-In-Kind donations offered to any Creighton University school, college or department by any donor.

AMENDMENT OR TERMINATION OF THIS POLICY
Creighton University reserves the right to modify, amend or terminate this policy at any time.
PURPOSE

In support of its mission, the Creighton University (the “University”) maintains a long-term strategic plan. The strategic plan establishes University-wide priorities as well as University-wide and divisional objectives. The University develops a capital plan to support these priorities and objectives.

The University’s use of debt plays a critical role in ensuring adequate funding for the capital plan as well as providing a cost-effective source of funding for other purposes. By linking the objectives of its Debt Policy to its strategic objectives, the University ultimately increases the likelihood of achieving its mission.

SCOPE

The Debt Policy covers all forms of debt including long-term, short-term, fixed-rate, and variable-rate debt. It also covers other forms of financing including both on-balance sheet and off-balance sheet structures, such as leases, and other structured products used with the intent of funding capital projects.

The use of derivatives is considered when managing the debt portfolio and structuring transactions. Conditions guiding the use of derivatives are addressed in a separate Interest Rate Risk Management Policy.

OBJECTIVES

The objectives of this policy are to:

(i) Outline the University’s philosophy on debt

(ii) Establish a control framework for approving and managing debt

(iii) Define reporting guidelines

(iv) Establish debt management guidelines

The Debt Policy formalizes the link between the University’s strategic plan and the issuance of debt. Debt is a limited resource that must be managed strategically in order to best support University priorities.
The policy establishes a control framework to ensure that appropriate discipline is in place regarding capital rationing, reporting requirements, debt portfolio composition, debt servicing, and debt authorization. It establishes guidelines to ensure that existing and proposed debt issues are consistent with financial resources to maintain an optimal amount of leverage, a strong financial profile, and a strategically optimal credit rating.

Under this policy, debt is being managed to achieve the following goals:

(i) Maintaining access to capital and financial markets.

(ii) Managing the University’s credit rating to meet its strategic objectives while maintaining the highest acceptable creditworthiness and most favorable relative cost of capital and borrowing terms;

(iii) Optimizing the University’s debt mix (i.e. short-term and long-term, fixed-rate and floating-rate, traditional and synthetic) for the University’s debt portfolio;

(iv) Managing the debt structure and maturity profile to meet liquidity objectives and make funds available to support future capital projects and strategic initiatives;

(v) Coordinating debt management decisions with asset management decisions to optimize overall funding and portfolio management strategies.

The University may use debt to accomplish critical priorities by more prudently using debt financing to accelerate the initiation or completion of certain projects, where appropriate. As part of its review of each project, the University evaluates all funding sources to determine the optimal funding structure to achieve the lowest cost of capital.

OVERSIGHT

The Vice President for Finance (“VP Finance”) is responsible for implementing this policy and for all debt financing activities of the University. The policy and any subsequent, material changes to the policy are approved by the Creighton University’s Board of Trustees (“Board”). The approved policy provides the framework under which debt management decisions are made. The VP Finance may delegate responsibilities for administration of this Debt Policy.

The Budget and Finance Committee of the Board will review the policy on an annual basis to ensure that the provisions are consistent with the goals of the University and capital market and credit conditions.
Policies and Procedures

The exposure limits listed in the policy are monitored on a regular basis by the VP Finance. The VP Finance reports regularly to the Senior Vice President for Operations and the Board on the University’s debt position and plans.

DEBT AFFORDABILITY AND CAPACITY

In assessing its current debt levels, and when planning for additional debt, the University takes into account both its debt affordability and debt capacity. Debt affordability focuses on the University’s ability to service its debt through its operating budget and identified revenue streams and is driven by strength in income and cash flows. Debt capacity focuses on the University’s financial leverage in terms of debt funding as a percentage of the University’s total capital.

The University considers many factors in assessing its debt affordability and debt capacity including its strategic plan, ability to access capital markets and alternative sources of funding. The University uses four key ratios to provide a quantitative assessment of debt affordability and debt capacity.

Debt Affordability Measures

Debt Burden Percentage
This ratio measures the University’s debt service burden as a percentage of total university expenses. The target for this ratio is intended to maintain the University’s long-term operating flexibility to finance existing requirements and new initiatives.

\[
\text{Annual Debt Service / Total Operating Expenses} \quad \text{Target} < 5\%
\]

The measure is based on aggregate operating expenses as opposed to operating revenues because expenses typically are more stable (e.g. revenues may be subject to one-time operating gifts, investment return fluctuations, variability of health services revenues, etc.) and better reflect the operating base of the University. This ratio is adjusted to reflect any non-amortizing or non-traditional debt structures that could result in significant single year fluctuations including the effect of debt refundings.

Debt Service Coverage Ratio
This ratio measures the University’s ability to cover debt service requirements with revenues available for operations. The target established is intended to ensure that operating revenues are sufficient to meet debt service requirements and that debt service does not consume too large a portion of income.

\[
(\text{Operating Gain/(Loss)} + \text{Interest Expense + Depreciation}) / \text{Annual Debt Service} \quad \text{Target} > 2.0x
\]
This ratio is adjusted to reflect any non-amortizing or non-traditional debt structures that could result in significant single year fluctuations including the effect of debt refundings.

### Debt Capacity Measures

#### Viability Ratio

This ratio indicates one of the most basic determinants of financial health by measuring the availability of liquid and expendable net assets to aggregate debt. The ratio measures the medium to long-term health of the University’s balance sheet and debt capacity and is a critical consideration of universities with high credit quality.

Many factors influence the viability ratio, affecting both the assets (e.g., investment performance, philanthropy) and liabilities (e.g., timing of bond issues), and therefore the ratio is best examined in the context of changing market conditions so that it accurately reflects relative financial strength.

\[
\frac{(\text{Unrestricted Net Assets} + \text{Temporarily Restricted Net Assets} - \text{Net Investment in Plant})}{\text{Total Debt}} \quad \text{Target} > 1.1x
\]

#### Debt Capitalization Percentage

This ratio measures what percentage of University capital comes from debt. A University that relies too heavily on debt capital may risk being over-leveraged and potentially reduce its access to capital markets. Conversely, a university that does not strategically utilize debt as a source of capital may not be optimizing its funding mix, thereby sacrificing access to low-cost funding to invest in mission objectives.

\[
\frac{\text{Total Debt}}{\text{Total Net Assets} + \text{Total Debt}} \quad \text{Target} < 25\%
\]

### Use of Ratios in Managing University Credit Ratings

The ratios and limits are not intended to track a specific rating, but rather to help the University maintain a competitive financial profile, funding for facilities needs and reserves, and adequate debt service coverage.

The Debt Policy is shared with external credit analysts and other parties in order to provide them with background on the University’s philosophy on debt and management’s assessment of debt capacity and affordability.
FINANCING SOURCES

The University recognizes that there are numerous types of financing structures and funding sources available, each with specific benefits, risks, and costs. All potential funding sources are reviewed by management within the context of the Debt Policy and the overall portfolio to ensure that any financial product or structure is consistent with the University’s objectives. Regardless of what financing structure is utilized, due-diligence review must be performed for each transaction, including (i) quantification of potential risks and benefits, and (ii) analysis of the impact on University creditworthiness and debt affordability and capacity.

**Tax-Exempt Debt**
The University recognizes that tax-exempt debt is a significant component of the University’s capitalization due in part to its substantial cost benefits; therefore, tax-exempt debt is managed as a portfolio of obligations designed to meet long-term financial objectives rather than as a series of discrete financings tied to specific projects. The University manages the debt portfolio to maximize its utilization of tax-exempt debt relative to taxable debt whenever possible. In all circumstances, however, individual projects continue to be identified and tracked to ensure compliance with all tax and reimbursement regulations.

For tax-exempt debt, the University will maximize the external maturity of any tax-exempt bond issue, subject to prevailing market conditions and opportunities and other considerations, including applicable regulations.

**Taxable Debt**
In instances where certain of the University’s capital projects do not qualify for tax-exempt debt, the use of taxable debt may be considered. The taxable debt market offers certain advantages in terms of liquidity and marketing efficiency; such advantages will be considered when evaluating the costs and benefits of a taxable debt issuance.

**Commercial Paper**
Commercial paper provides the University with interim financing for projects in anticipation of philanthropy or planned issuance of long-term debt. The use of commercial paper also provides greater flexibility on the timing and structuring of individual bond transactions. This flexibility also makes commercial paper appropriate for financing equipment and short-term operating needs. The University recognizes that the amount of commercial paper is limited by the Debt Policy ratios, the University’s variable-rate debt allocation limit, and the University’s available liquidity support.
University-issued vs. Authority-issued Debt
In determining the most cost effective means of issuing debt, the University evaluates the merits of issuing debt directly vs. issuing debt through Douglas County or other authorized issuer (e.g., Nebraska Educational Financing Authority.)

On a regular basis, the University performs a cost benefit analysis between these two options and takes into consideration the comparative funding costs, flexibility in market timing, and bond ratings of each alternative. The University also takes into consideration the future administrative flexibility of each issue such as the ability to call and/or refund issues at a later date, as well as the administrative flexibility to structure and manage the debt in a manner that the University believes to be appropriate.

Derivative Products
Management recognizes that derivative products may enable more opportunistic and flexible management of the debt portfolio. Derivative products, including interest rate swaps and locks, may be employed primarily to manage or hedge the University’s interest rate exposure. The University utilizes a framework to evaluate potential derivative instruments by considering (i) its current variable-rate debt allocation, (ii) existing market and interest rate conditions, (iii) the impact on future financing flexibility, and (iv) the compensation for assuming risks or the costs for eliminating certain risks and exposure. Risks include, but are not limited to, tax risk, interest rate risk, liquidity risk, counterparty credit risk, basis risk, and any other potential risks either imposed or removed through the execution of any transaction.

The University analyzes and quantifies the cost/benefit of any derivative instrument relative to achieving desirable long-term capital structure objectives. Under no circumstances will a derivative transaction be utilized that is not understood fully by management or that imposes inappropriate risk on the University. All derivative transactions will be governed by the University’s Interest Rate Risk Management Policy.

Other Financing Sources
Given limited debt capacity and substantial capital needs, opportunities for alternative and non-traditional transaction structures may be considered, including off-balance sheet financings. The University recognizes these types of transactions often can be more expensive than traditional University debt structures; therefore, the benefits of any potential transaction must outweigh any potential costs.

All structures can be considered only when the economic benefit and the likely impact on the University’s debt capacity and credit have been determined. Specifically, for any third-party or developer-based financing, management ensures the full credit impact of the structure is evaluated and quantified.
PORTFOLIO MANAGEMENT OF DEBT

The University considers its debt portfolio in aggregate, that is, it optimizes the portfolio of debt for the entire University rather than on a project-by-project basis while taking into account the University’s cash and investment portfolio. Therefore, management makes decisions regarding project prioritization, debt portfolio optimization, and financing structures within the context of the overall needs and circumstances of the University.

Variable-Rate Debt
The University recognizes that a degree of exposure to variable interest rates within the University’s debt portfolio is desirable in order to:

(i) take advantage of repayment/restructuring flexibility;

(ii) benefit from historically lower average interest costs;

(iii) provide a “match” between debt service requirements and the projected cash flows from the University’s assets; and

(iv) diversify its pool of potential investors.

Management monitors overall interest rate exposure, analyzes and quantifies potential risks, including interest rate, liquidity and rollover risks, and coordinates appropriate fixed/variable allocation strategies. The portfolio allocation to variable-rate debt may be managed or adjusted through (i) the issuance or redemption of debt in the conventional debt market (e.g. new issues and refundings) and (ii) the use of interest rate derivative products including swaps.

The amount of variable-rate debt outstanding (adjusted for any derivatives) shall not exceed the following target percentage of the University’s outstanding debt. This limit is based on the University’s desire to: (i) limit annual variances in its interest payments, (ii) provide sufficient structuring flexibility to management, and (iii) utilize variable-rate debt (including derivatives) to optimize debt portfolio allocation and minimize costs.

\[
\text{Total Variable-rate Debt (including synthetic) / Total Debt Target \< 35\%}
\]
Refinancing Outstanding Debt
The University monitors its debt portfolio on a continual basis to assure portfolio management objectives are being met and to identify opportunities to lower its cost of funding, primarily through refinancing outstanding debt.

The University monitors the prices and yields of its outstanding debt and attempts to identify potential refunding candidates by examining refunding rates and calculating the net present value of any refunding savings after taking into account all transaction costs. The University may choose to pursue refundings for economic and/or legal reasons.

Liquidity Requirements
The University’s portfolio of variable-rate debt and commercial paper require liquidity support in the event of the bonds or paper being put back to the University by investors. Generally, the University can purchase liquidity support externally from a bank in the form of a standby bond purchase agreement, letter of credit or line of credit. In addition, the University can also use its own capital in lieu of or to supplement external facilities. Alternatively, it can utilize variable-rate structures that do not require liquidity support (e.g. auction-rate products.)

Just as the University manages its debt on a portfolio basis, it also manages its liquidity needs by considering its entire asset and debt portfolio, rather than managing liquidity solely on an issue-specific basis. This approach permits institution-wide evaluation of desired liquidity requirements and exposure, minimizes administrative burden, and reduces total liquidity costs.

A balanced approach is used to provide liquidity support to enhance credit for variable-rate debt, through a combination of external bank liquidity, self-liquidity, auction market or derivative structures. Using a variety of approaches limits dependence on an individual type or source of credit; it also allows for exposure to different types of investors. The University must balance liquidity requirements with its investment objectives and its cost and renewal risk of third-party liquidity providers.

Further, a portfolio-approach to liquidity can enhance investment flexibility, reduce administrative requirements, lower total interest costs, and reduce the need for external bank liquidity.

Overall Exposure
The University recognizes that it may be exposed to interest rate, third-party credit, and other potential risks in areas other than direct University debt (e.g., off-balance sheet transactions, counterparty exposure in the investment portfolio, etc.) and, therefore, exposures are considered on a comprehensive University-wide basis.
STRATEGIC DEBT ALLOCATION

Recognizing that financial resources are not sufficient to fund all capital projects, management must allocate debt strategically, continuing to explore alternate sources of funding for projects. External support and philanthropy remain critical to the University’s facilities investment plan.

Management allocates the use of debt financing internally within the University to reflect the prioritization of debt resources among all uses, including plant and equipment financing, academic projects, and projects with institutional impact. Generally, the University favors debt financing for those projects critical to the attainment of its strategic goals and those projects with identified revenue streams for the repayment of debt service and incremental operating costs.

Each capital project is analyzed at its inception to ensure that capital is used in the most effective manner and in the best interests of the University. There is an initial institutional review of each project, prior to its inclusion in the University’s strategic plan, to determine if debt leveraging would be desirable even if not requested by the project sponsor.

As part of this initial institutional review, the University also will assess, based on the project’s business plan, the sufficiency of revenues to support any internal loans. If the University determines that collateral is necessary, it may require the entity to segregate unrestricted funds for this purpose.

In general, a given project should generate sufficient revenue or be supported by designated gifts such that the anticipated debt service coverage attributable to the project is at least 1.25:1.

CENTRAL LOAN PROGRAM MANAGEMENT

Each division is responsible for the repayment of all funds borrowed from the central loan program, plus interest and certain fees established in the University’s internal lending policies, regardless of the internal or external source of funds.

Loan structures with standard financial terms are offered to divisional borrowers. The University may provide for flexible financing terms in order to accommodate individual divisions if it is determined to be in the University’s best interest. The VP Finance clearly articulates the policies and procedures for the assumption and repayment of debt to all borrowers.
De-linking External and Internal Debt Structures
The University has adopted a central loan program under which it provides funding for projects across schools and divisions under the guidance of the VP Finance. In this regard, the University has established a pool of financing resources, including debt, for a central source of capital.

The benefits of this program include:

(i) enabling the structuring of transactions in the best economic interests of the University that otherwise wouldn’t be possible on a project-specific basis;

(ii) providing continual access to capital for borrowers and permitting the University to fund capital needs on a portfolio basis rather than on a project-specific basis;

(iii) funding specific projects with predictable financial terms,

(iv) achieving the lowest average internal borrowing costs while minimizing volatility in interest rates,

(v) permitting prepayment of internal loans at any time without penalty, and

(vi) allowing the University to effectively manage its relationships with various financial institutions.

The central loan program can access funds from a variety of sources to originate loans to divisions. The University manages its funding sources on a portfolio basis, and therefore payments from divisions are not tied directly to a particular source of funds. (Note: Due to federal tax and reimbursement requirements, actual debt service for certain projects still must be tracked.)

Blended Interest Rate
The University charges a blended interest rate to its divisions based on its cost of funding. In some instances, at the discretion of the VP Finance, the type and useful life of the project being financed may affect the appropriate term and interest rate of any loan.

This blended interest rate may change periodically to reflect changes in the University’s average aggregate expected long-term cost of borrowing. The blended interest rate may also include a reserve for interest rate stabilization purposes.
In addition to charging borrowers interest, the central loan program collects amounts to pay for costs of administering the debt portfolio. These costs are clearly articulated to divisions, and are passed on to borrowers in the form of a rate surcharge and an upfront fee for loan origination. These charges may be reviewed and adjusted from time-to-time.

APPROVAL PROCESS

All transactions for debt issuance or major modifications to existing debt agreements shall be reviewed with the Budget and Finance Committee. If the Budget and Finance Committee approves a transaction, it will recommend that such be authorized through a Board or Executive Committee resolution. Within the authorizing resolution, the Board or Executive Committee shall establish financing parameters for the transaction.

In the event that the Budget and Finance Committee does not elect to recommend a transaction to the Board or Executive Committee and University management feels that such transaction is in the best interest of the University, the VP Finance shall have the right to present the transaction for approval directly to the Board or Executive Committee.

As part of the approval resolutions, the Board or Executive Committee shall delegate the authority to approve the pricing of such debt, the execution of related financing documents, and the on-going administration of such debt to the VP Finance and the Associate Vice President for Finance.
Policies and Procedures

SECTION: Financial

CHAPTER: General

POLICY: Interest Rate Risk Management Policy

PURPOSE

Creighton University maintains a Debt Policy which provides guidelines on the authorization and management of debt. The University manages its debt portfolio on a consolidated basis and makes debt management decisions to achieve the lowest cost of debt capital and maximize its portfolio objectives. The use of derivatives can play a key role in managing the University’s debt portfolio.

In certain circumstances, derivatives are an effective way for the University to adjust its mix of fixed- and floating-rate debt and manage interest rate exposures. Derivatives may also be an effective way to manage liquidity risks. The University’s philosophy is to use derivatives strategically to achieve asset and liability portfolio objectives and hedge existing exposures. Derivatives will not be used to create leverage or to speculate on the movement of interest rates.

SCOPE

The Interest Rate Risk Management Policy applies to any derivatives used for the purpose of hedging interest rate exposures.

Additionally, any decisions made regarding the use of derivatives must take into consideration the resulting impact under the University’s Debt Policy.

OBJECTIVES

This policy is intended to:

(i) Outline the University’s philosophy on derivatives

(ii) Provide guidelines on the use of derivatives

(iii) Identify approved derivative instruments

(iv) Establish a control framework related to the use of derivatives

The University views derivatives as a tool to achieve its asset and liability management objectives. As a result, it is the University’s philosophy to use derivatives strategically in support of this cause.
It is also the University’s philosophy to not use derivatives to create leverage or speculate on interest rate movements. The University recognizes that the prudent and selective use of derivatives may help it to lower its cost of debt capital and manage its interest rate exposure.

This policy provides guidelines on the use of derivatives including the circumstances under which they may be used and the factors that are considered in deciding whether to use them. Derivatives may be used to achieve the following objectives:

(i) Reduce the cost for debt financing when compared to conventional debt structures

(ii) Manage interest rate volatility

(iii) Manage fixed- and variable-rate debt mix

(iv) Help match the cash flows from assets with those from liabilities

(v) Hedge future debt issues or synthetically advance refund bonds

The policy also outlines a control framework to ensure that an appropriate discipline is in place regarding the use of derivatives. Controls exist to address both operational risks and exposure risks.

Oversight

The Vice President of Finance ("VP Finance") is responsible for implementing this policy and for all interest rate risk management activities of the University. The policy and any subsequent, material changes to the policy are approved by the University’s Board of Trustees ("Board"). The VP Finance may delegate responsibilities for administration of this Debt Policy.

The Budget and Finance Committee of the Board will review the policy on an annual basis to ensure that the provisions are consistent with the goals of the University and capital market and credit conditions.

The VP Finance provides oversight and monitors all derivative transactions and, at least annually, reports to the Senior Vice President for Operations and the Board on the University’s outstanding derivatives.
DERIVATIVE USE GUIDELINES

The University may use derivatives to achieve the lowest possible cost of debt funding, manage its exposure to interest rate volatility, and/or match the timing and nature of cash flows associated with its assets and liabilities. The University may accomplish this by hedging the interest rate volatility of projected debt issuances or by using derivatives to adjust its exposure to floating interest rates.

To determine its portfolio exposure, the University looks at the composition of its outstanding assets and liabilities (adjusted for any hedges) and the change in this composition over a predetermined planning horizon. Taking into account the potential for future uncertainty, the University determines what, if any, action should be taken to keep its portfolio exposures at desirable levels over this period.

In determining when to hedge, the University monitors its interest rate exposure, the capital markets, and its future funding and liquidity requirements. The University analyzes and quantifies the cost/benefit of any derivative instrument relative to achieving desirable long-term capital structure objectives. Before entering into a derivative, the University evaluates its risks including, but not limited to: tax risk, interest rate risk, liquidity risk, credit risk, basis risk, rollover risk, termination risk, counterparty risk, and amortization risk. The University also evaluates the impact the hedge will have on its debt portfolio at the inception of the hedge and over the planning period.

When evaluating its hedging options, the University generally prefers the lowest cost, most liquid, and most flexible hedging strategy available. In instances where no one hedging strategy meets all these needs, the University prioritizes these requirements to decide on an optimal strategy.

At their inception, derivatives are chosen to closely match the exposures being hedged. As time passes, the University’s debt management objectives may change and any decisions will be made with the best information available at that time regardless of hedges that may be in place. For instance, the University may use derivatives to hedge future interest rates associated with a fixed-rate bond issuance. If at the time of issuance it is deemed more beneficial to issue floating-rate bonds, then the University will not let its past hedging decisions constrain its current bond issuance decisions.

In addition, management discloses the impact of all derivatives on the University’s financial statements in compliance with relevant accounting requirements and includes their effects in calculating the Debt Policy ratios.

This policy shall apply to the execution of new derivative transactions as well as to the termination, unwinding or modification of existing instruments.
ALLOWABLE DERIVATIVE INSTRUMENTS

The University recognizes that there are numerous derivatives of varying degrees of complexity. The University attempts to avoid structural complexity in its use of derivatives and believes the following instruments, used alone or in combination with each other, allow for sufficient flexibility to help the University meet its interest rate risk management objectives.

**Interest Rate Swaps** – Swaps are contracts to exchange payments based on different interest rate indices, generally with one such index based on interest rates that are fixed at a specific rate for the term of the contract and the other based on interest rates that are to be adjusted from time to time throughout the term of the contract. The University may utilize these contracts to change its mix of fixed rates and floating rates. They may also be used as a means to hedge future financings.

**Interest Rate Call or Put Options** – An option gives the holder a right, but not an obligation, to buy or sell a security at or by a specified date(s) at an agreed upon price in exchange for the payment of a premium. Interest rate options, typically in the form of interest rate caps or floors, are designed to provide protection against interest rates being above a certain cap rate or below a certain floor rate. Options may be used when the purchaser faces an asymmetrical risk profile, for instance, the risk that interest rates may rise prior to a new debt issuance. Options to enter into swaps, or swaptions, give the buyer the right to enter into a swap as a fixed-rate or floating-rate payer depending on the buyer’s interest rate exposure.

The University will not sell options, except to the extent they are sold to better hedge an underlying exposure that contains an offsetting option position. For example, a bond with a call option held by the University may be hedged better by entering into a derivative with an offsetting sold call option.

**Interest Rate Locks** – A rate lock is a forward contract that represents a sale of a specific benchmark security (e.g., U.S. Treasuries, LIBOR, or tax-exempt indices) or other appropriate benchmark security at an agreed price or interest rate. The University may utilize these contracts to help lock in a future financing rate.

Before entering into a derivative transaction, the University first gains a full understanding of the transaction and performs appropriate due diligence, such as (i) a quantification of potential risks and benefits, and (ii) an analysis of the impact on University’s debt portfolio.
EXPOSURE CONTROLS

The University has established exposure controls to address program risks.

The University manages its derivatives exposure by looking at its derivatives portfolio independently and also in the context of its overall asset and liability portfolios. Prior to entering into a derivative transaction, the University will examine the impact of such trade independently and on the asset and liability portfolios as a whole.

Derivative transactions shall be governed by and subject to the terms and conditions set forth in an International Swap and Derivative Association, Inc. (“ISDA”) Master Agreement, Credit Support Annex (if required) and Confirmation. Such ISDA documents will be established with each counterparty with which the University transacts derivatives.

The following establishes limits related to counterparty credit ratings, and the maximum allowable percentage of floating rate debt.

**Maximum Percentage of Floating Rate Debt** – The University’s outstanding debt portfolio will have no more than 35% of the principal amount in floating rate debt, as described in its Debt Policy. This percentage is calculated to factor in the effects of interest rate derivatives.

**Counterparty Credit Exposure** – All derivative counterparties will be rated A3 or better by Moody’s and A- or better by Standard & Poors. The maximum allowable credit exposure, determined by the net mark-to-market of all trades with a single counterparty, will be $25 million for counterparties rated Aa2/AA or better and $10 million for counterparties rated less than Aa2/AA.

The University may take steps to reduce its exposure to a counterparty by either (i) requiring the counterparty to post collateral in the full amount of the exposure (all the while abiding by the terms of any Credit Support Annex between the University and the counterparty), (ii) terminating all or a portion of its outstanding contract(s) with the counterparty, or (iii) requiring the counterparty to obtain swap insurance or provide another form of third-party security agreeable to the University.
### Policies and Procedures

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<td>Interest Rate Risk Management Policy</td>
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**APPROVAL PROCESS**

All new derivative transactions or major modifications to existing derivative agreements shall be reviewed with the Budget and Finance Committee. If the Budget and Finance Committee approves a transaction, it will recommend that such be authorized through a Board or Executive Committee resolution. Within the authorizing resolution, the Board or Executive Committee shall establish financing parameters for the transaction.

In the event that the Budget and Finance Committee does not elect to recommend a transaction to the Board or Executive Committee and University management feels that such transaction is in the best interest of the University, the VP Finance shall have the right to present the transaction for approval directly to the Board or Executive Committee.

As part of the approval resolutions, the Board or Executive Committee shall delegate the authority to approve the pricing of such derivative, the execution of related financing documents, and the on-going administration of such derivative to the VP Finance and the Associate Vice President for Finance.
**Policies and Procedures**

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<tr>
<td>Short-Term Investment Policy</td>
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**PURPOSE**

The purpose of this Policy is to establish guidelines for investment of Creighton University’s (the “University”) excess operating and special purpose cash balances.

In addition to this Investment Policy, the University may be subject to additional limitations and restrictions set forth in loan and credit agreement arrangements.

**SCOPE**

This policy will apply to cash balances generated by the University’s operating activities and to special purpose accounts such as funds held for University loans to students, debt service reserve accounts required by the University’s loan agreements or donor contributions for specified construction projects. Except for cash in certain legally restricted and special accounts, the University will consolidate cash balances to optimize liquidity management and investment earnings and to increase efficiencies with regard to investment pricing, custody/trust and administration.

All investment activity related to the University’s endowment and long-term investment pool will be governed by the Investment Policy Statement and therefore is not subject to this policy.

**OBJECTIVE**

To generate a positive return on the University’s excess cash balances while maintaining adequate liquidity to meet working capital needs and to reduce outstanding debt.

**DELEGATION OF AUTHORITY**

Subject to the restriction set forth in Restricted Investments, the Board of Trustees of the University hereby delegates to the Vice President for Finance the responsibility for managing the University’s cash and for making investments in and taking redemptions from money market accounts or other cash equivalent instruments as described in Permitted Investments. The Vice President for Finance may delegate responsibility for these investment decisions and transactions to other employees of the University as appropriate.
ADMINISTRATION AND CONTROL

It shall be the responsibility of the Vice President for Finance or his or her designee to establish reasonable controls and procedures to assure: (i) compliance with this Policy; (ii) the appropriate execution of investment transactions; (iii) frequent monitoring of investment positions; and (iv) the proper accounting of investment activity. The Vice President for Finance or designee shall make investments decisions as allowed by this Policy, including the investment instrument, amount and maturity, to meet the objective as established from time to time.

PERMITTED INVESTMENTS (subject to the limitations set forth in Appendix A).

i. Securities issued or directly and fully guaranteed or insured by the United States or any agency or instrumentality thereof (provided that the full faith and credit of the United States is pledged in support thereof) having maturities of not more than one year from the date of acquisition;

ii. Marketable direct obligations issued by the District of Columbia or any state of the United States or any political subdivision of the District of Columbia or any such state or any public instrumentality thereof maturing within one year from the date of acquisition thereof and, at the time of acquisition, having one of the two highest ratings obtainable from either S&P or Moody’s;

iii. Dollar denominated time deposits and certificates of deposit of any commercial bank having, or which is the principal banking subsidiary of a bank holding company having a long-term unsecured debt rating of at least “A” or the equivalent thereof from S&P or “A2” or the equivalent thereof from Moody’s with maturities of not more than one year from the date of acquisition;

iv. Repurchase obligations with a term of not more than 30 days for underlying securities of the types described in item (i) above entered into with any bank meeting the qualifications specified in item (iii) above;

v. Commercial paper and variable or fixed rate notes issued by any entity incorporated in the United States rated at least A-1 or the equivalent thereof by S&P or at least P-1 or the equivalent thereof by Moody’s, and in each case maturing not more than one year after the date of acquisition;

vi. Investments in money market funds (highly liquid mutual funds that invest in short-term securities and seek to maintain a stable net asset value of $1 per share) rated at least AA by Standard & Poors or at least A2 by Moody’s and substantially all of whose assets are comprised of securities of the types described in clauses (i) through (v) above; and
Certificates of deposit issued by, bank deposits in, Eurodollar deposits through, bankers’ acceptances of, and repurchase agreements covering government securities executed by, any bank incorporated under the laws of the United States of America or any State thereof and having on the date of such investment combined capital, surplus and undivided profits of at least one hundred fifty million dollars, or total assets of at least one billion dollars, in each case due within one year after the date of the making of the investment.

RESTRICTED INVESTMENTS

Unless specifically approved in advance by the Board of Trustees of the University, the purchase or acquisition of any equity or debt securities (including derivatives) or non-marketable investments (such as partnerships, joint ventures, private entities) not described under Permitted Investments is prohibited.

APPENDIX A
Investment Limits

<table>
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<th>Instrument</th>
<th>Each Issuer</th>
<th>Aggregate Portfolio</th>
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<tr>
<td>Overnight Sweep (e.g., Eurodollar account)</td>
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<td>US Govt./Agency Securities</td>
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<td>Time Deposits/CDs</td>
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<td>Repurchase Obligations</td>
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PURPOSE

As part of the University’s enterprise risk management program, the use of hedging tools (i.e. derivatives) can play a key role in managing the University’s financial risk.

The University’s philosophy is to use hedging tools strategically to reduce financial risk on existing exposures. Hedging tools will not be used to create leverage or to speculate on the movement of prices.

SCOPE

The Hedging Policy applies to the use of hedging tools (derivatives) used for the purpose of reducing financial risk due to the University’s exposure to market factors such as commodity prices and foreign exchange rates. The Hedging Policy does not apply to the management of interest rate exposures which is governed by The Interest Rate Risk Management Policy included as part of the University’s Debt Policy.

OBJECTIVES

This policy is intended to:

(v) Outline the University’s philosophy on hedging;

(vi) Provide guidelines on the use of derivatives; and

(vii) Establish a control framework related to the use of derivatives.

The University considers hedging a tool to transform unacceptable risks into an acceptable form. The goal of any hedging program should be to help the University achieve the optimal risk profile that balances the benefits of protection against the costs of hedging. The University will not use hedging tools to speculate on the movement of prices or to create leverage. The University recognizes that the prudent and selective use of derivatives may help it to mitigate exposure to price movements of certain commodities or indices and to lower its operating costs.

OVERSIGHT

The Senior Vice President of Operations (“SVP Operations”) is responsible for implementing this policy. The policy and any subsequent, material changes to the policy are approved by the Budget and Finance Committee of the University’s Board of Trustees (“Board”). The SVP Operations may delegate responsibilities for administration of this policy.
Policies and Procedures

The Budget and Finance Committee of the Board will review the policy on an annual basis to ensure that the provisions are consistent with the goals of the University and market conditions.

The SVP Operations provides oversight and monitors all derivative transactions. Annual reviews of outstanding hedging programs will be submitted to the Budget and Finance Committee to ensure the program design continues to be effective.

DERIVATIVE USE GUIDELINES

Pursuant to this policy, derivatives may be used to manage price volatility of commodities or foreign currencies used in the operation of the University. Items to consider in deciding whether to hedge the risk include:

i) Materiality of the potential loss or exposure that might occur if the exposure is not hedged;
ii) The costs of hedging;
iii) The volatility of the exposure being hedged; and
iv) Any risks inherent to the derivative, such as counterparty risk.

When evaluating its hedging options, the University generally prefers the lowest cost, most liquid, and most flexible hedging strategy available. In instances where no one hedging strategy meets all these needs, the University prioritizes these requirements to decide on an optimal strategy.

ALLOWABLE DERIVATIVE INSTRUMENTS

The University recognizes that there are numerous derivatives of varying degrees of complexity. The University attempts to avoid structural complexity in its use of derivatives and believes the following instruments, used alone or in combination with each other, allow for sufficient flexibility to help the University meet its commodity price risk management objectives. These derivatives may take the form of stand-alone transactions or as contractual provisions of a service or purchase agreement.

- **Forward Purchase Contracts**—Contract determining the volume and/or price of an underlying commodity to be paid or received on an obligation beginning at a future start date.

- **Futures**—Obligation to buy or sell an underlying instrument at a certain price and date. Transactions are exchange traded and consist of standardized contract terms specifying quantity and quality of the instrument, price per unit, date and method of delivery (if any).
**Swaps** – Contract to exchange payments based on different indices or prices, generally with one price fixed at a specific level for the term of the contract and the other that is to be adjusted from time to time throughout the term of the contract.

**Call or Put Options** – An option gives the holder a right, but not an obligation, to buy or sell a commodity or currency at or by a specified date(s) at an agreed upon price in exchange for the payment of a premium. Options, typically in the form of caps or floors, are designed to provide protection against prices being above a certain cap or below a certain floor. Options to enter into swaps, or swaptions, give the buyer the right to enter into a swap depending on the buyer’s exposure. Pursuant to this policy, the University will not sell options.

Before entering into a derivative transaction, the University first gains a full understanding of the transaction and performs appropriate due diligence, such as (i) a quantification of potential risks and benefits; and (ii) an analysis of the impact on the University’s risk exposure and cost structure.

**EXPOSURE CONTROLS**

The University has established exposure controls to address program risks.

The University manages its derivatives exposure by looking at its derivatives portfolio independently and also in the context of its overall asset and liability portfolios. Prior to entering into a derivative transaction, the University will examine the impact of such trade independently and on the asset and liability portfolios as a whole.

To the extent practicable, derivative transactions shall be governed by and subject to the terms and conditions set forth in an International Swap and Derivative Association, Inc. (“ISDA”) Master Agreement, Credit Support Annex (if required) and Confirmation. Such ISDA documents will be established with each counterparty with which the University transacts derivatives. In those cases where the derivative transaction is embedded in the contract structure and terms governing the purchase and sale of the underlying commodity, the University will ensure that the contract affords reasonable legal protection in the event of termination or default.

**Counterparty Credit Exposure** – All derivative counterparties will be rated A3 or better by Moody’s and A- or better by Standard & Poors. The maximum allowable credit exposure, determined by the net mark-to-market of all trades with a single counterparty, will be $10 million for counterparties rated Aa2/AA or better and $5 million for counterparties rated less than Aa2/AA. If a counterparty does not have a public credit rating, the maximum net exposure will be $2 million and the University will perform a credit review prior to entering into a derivative transaction.
The University may take steps to reduce its exposure to a counterparty by either (i) requiring the counterparty to post collateral in the full amount of the exposure (all the while abiding by the terms of any Credit Support Annex between the University and the counterparty), (ii) terminating all or a portion of its outstanding contract(s) with the counterparty, or (iii) requiring the counterparty to obtain swap insurance or provide another form of third-party security agreeable to the University.

**APPROVAL PROCESS**

All new derivative transactions or major modifications to existing derivative agreements shall be reviewed with and approved by the Budget and Finance Committee. Further, derivative transactions embedded in existing contractual arrangements shall be approved by the Budget and Finance Committee on an annual basis.
1. PURPOSE

This policy provides procedures and guidelines to ensure that all of the outstanding Tax-Advantaged Bonds of the University remain in compliance with federal tax law requirements. For the purposes of this policy, “Tax-Advantaged Bonds” or “Bonds” means, collectively, an Issuer’s Tax Credit Bonds and Tax-Exempt Bonds of which Creighton University (the “University”) is a beneficiary. “Tax-Exempt Bonds” means the one or more series of bonds or other form of tax-exempt obligations that an Issuer has previously issued or may in the future issue for the benefit of the University, the interest on which is excludable from gross income of the owners thereof pursuant to Sections 103 and 141-150 of the Internal Revenue Code of 1986, as amended, and Income Tax Regulations promulgated pursuant thereto (the “Regulations,” and collectively with such Sections, the “Code”), and includes qualified 501(c)(3) Bonds. “Tax Credit Bonds” means the one or more series of governmental purpose tax credit bonds or other form of obligations that an Issuer has previously issued or may in the future issue for the benefit of the University that entitle an Issuer, the owners of the Tax Credit Bonds, or any other permitted party to either a credit against federal income tax liability or a refundable credit from the United States Treasury.

Certain of the University’s capital projects have been or will be financed, refinanced or reimbursed through the issuance of Bonds (the “Bond-Financed Property”). Tax-advantaged status is intended to remain throughout the life of the Bonds, but this status can be lost if certain applicable federal laws and regulations are not followed. Other negative consequences to the University can result from failure to comply with restrictions relating to arbitrage, timing and use of Bond proceeds, and other aspects of a Bond issue. A list of the Bond-Financed Property can be obtained from the University’s Vice President for Finance.

Remedial actions under the Code are sometimes available in the event of a failure to comply with these requirements. However, such remedies for non-compliance may not cover all violations of the requirements of the Code and other applicable requirements governing Tax-Advantaged Bonds benefiting the University. Certain remedial provisions also require that the non-compliance be identified and remedial action taken within a limited time after the violation. In instances where applicable remedial provisions are not available under the Code, the Issuer of the University’s Bonds, upon being directed by the University, may request a voluntary closing agreement to address the violation under the Internal Revenue Service’s Tax Exempt Bonds Voluntary Closing Agreement Program, described in IRS Notice 2008-31 (“VCAP”). This policy accordingly is also intended to provide written procedures to ensure timely identification of violations of federal tax requirements and timely correction of any identified violation through use of VCAP if self-remediation is not available under the Code. However, this policy does not address violations other than those related to federal tax requirements (e.g., sectarian use restrictions).
2. PROCEDURES AND GUIDELINES

2.1 General

2.1.1 The Vice President for Finance (the “Compliance Officer”) is responsible for monitoring the compliance of the Bonds with all federal tax law requirements, will contribute to the safeguarding of the federal tax status of the Bonds, and will conduct reviews at least annually of the elements set forth in this policy for each issue of Bonds and will annually report to the Budget & Finance and Audit & Compliance Committees of the Board of Trustees regarding compliance with this policy.

2.1.2 In general, records pertaining specifically to Bonds will be retained over a period not less than the life of the Bonds plus 4 years. Specific records to be retained are addressed below in Section 2.4 of this policy and Exhibit 1 attached.

2.1.3 Education, training and information regarding Bonds will be obtained by the Senior Vice President for Operations, the Compliance Officer, the Associate Vice President for Finance and the Director of External Finance GAAP & Tax Policy and Compliance from publications by a nationally recognized municipal bond attorney or firm of municipal bond attorneys (“Bond Counsel”), Internal Revenue Service publications and seminars and other means as deemed appropriate, including consultation with the Office of the General Counsel of the University, external counsel and/or Bond Counsel at the time each Bond issue is delivered, to discuss applicable provisions of the Tax and No Arbitrage Certificates (or similar document) that apply to Bond-financed or refinanced assets. The Tax Certificate and other federal tax related closing documentation are referred to in this policy collectively as the “Tax Closing Documentation.”

2.1.4 Filing of Form 8038 for each issue of Bonds shall be verified by the Compliance Officer by obtaining a copy of the filed 8038 from Bond Counsel with proof of filing.

2.1.5 The Compliance Officer, or his or her designee, will consult with the University’s tax advisors on an annual basis, or more frequently if necessary (e.g., based on results of the arbitrage calculations described in 2.3.1 below), to confirm reporting of required information regarding the Bonds on the University’s annual Form 990 and other required returns and filings. Copies of all such final returns are provided to the Senior Vice President for Operations and the Compliance Officer prior to filing. The Compliance Officer will monitor timely filing of such returns and proper and accurate inclusion of Bond related information required by Form 990 and Schedule K.
2.2 Bond Proceeds and Financed Assets: Investment and Private Use.

2.2.1 Bond proceeds will be invested and used as set forth in the Tax Certificates maintained in each respective Bond transcript.

2.2.2 The Tax Certificate will contain or have appended a schedule establishing each project’s expected costs and economic life and will be maintained in each respective Bond transcript. In the event a project is amended and certain elements are changed from those originally set forth in the project schedule described in this Section 2.2.2, the University will prepare upon completion of each project, or earlier if advised by Bond Counsel, an amendment to the schedule showing the final project costs (including those funded from interest earnings), the related economic life of the project components and such other applicable changes to the project as a whole.

2.2.3 Minimizing any private use associated with the Bond-Financed Property, and confirming that any private use falls within applicable safe harbors, is a priority of the University. Examples of private business use include (a) unrelated trade or business use (regardless of whether taxable income is generated) and (b) private use by parties other than the University and its students of the Bond-Financed Property, including particularly by independent contractors and vendors serving the University. Leasing of any portion of a Bond-Financed Property generally creates private use.

2.2.4 Generally, no more than 5% of the proceeds of Bonds may be used for private business use of the Bond-Financed Property. For purposes of the 5% limit on private business use, Bond issuance costs financed with Bond proceeds (generally approximately 2%) are included as private business use and reduce the amount of private use that can be conducted in the Bond-Financed Property.

2.2.5 Accordingly, contracts and agreements relating to use of the Bond-Financed Property (including, without limitation, management contracts, service contracts, joint ventures, operating agreements, leases and research contracts) will be required by the University’s Contract Policy and this policy to be reviewed prior to execution by the Office of the General Counsel and Bond Counsel for compliance with applicable federal requirements.

2.2.6 Upon closing, and throughout the term of the Bonds, the Compliance Officer will determine whether more than 5% of the proceeds of a Bond issue are invested, directly or indirectly, in federally insured deposits or accounts, or if the Bonds are otherwise directly or indirectly federally guaranteed and will consult with Bond Counsel in the event there is any question with respect to the Tax-Advantaged Bonds being federally guaranteed within the meaning of Section 149(b) of the Code.
2.2.7 (a) The Compliance Officer will establish such accounting controls as are necessary to guarantee that no more than the lesser of (i) 5% of the net proceeds or (ii) $15 million will be expended on projects used by persons other than (i) one or more governmental units, or (ii) a 501(c)(3) organization in related trades or businesses.

(b) The Compliance Officer will take such measures to ensure that the University retains its status as a 501(c)(3) organization at all times that any Tax-Advantaged Bonds are outstanding that have been issued for the benefit of the University.

(c) The Compliance Officer will establish such accounting controls as are necessary to guarantee that no more than 5% of net bond proceeds are loaned to any persons or entities that are not governmental units or 501(c)(3) organizations.

(d) The Compliance Officer will establish such accounting controls as are necessary to assure that all costs of issuance that are paid with bond proceeds are so paid no later than 180 days after the date of issuing the bonds.

The Compliance Officer will establish such accounting controls as are necessary to identify to the Compliance Officer whether there is a variance of greater than 10% in the amount of costs of issuance, credit enhancement costs and refunding or new money uses reported on the IRS Form 8038 for the bond issue.

(e) The Compliance Officer will establish such accounting controls, calendars and reporting procedures as are necessary to confirm that any time periods limiting spending have been met.

In connection with this procedure, for new money issues, the Compliance Officer will establish such accounting reports as are necessary to determine at least annually the amounts and percentages of bond proceeds that have been spent on the intended projects.

(f) The Compliance Officer will establish such accounting controls as are necessary to confirm that the proceeds are spent on the approved projects.

(g) The Compliance Officer will establish such accounting and review procedures as are necessary to record and approve a change from an expected qualified project to a qualified substitute project.
## Policies and Procedures

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### POLICY:

**Tax-Advantaged Bond Post-Issuance Compliance Policy**

| PAGE 5 OF 8 |

(h) The Compliance Officer will establish such accounting and review procedures as are necessary to arrange for qualified expenditures of any unspent moneys that remain after completion of the original list of projects to be financed by the Tax-Advantaged Bonds.

In connection with this procedure, the Compliance Officer will prepare a written, detailed explanation regarding why such proceeds remain unspent.

In connection with this procedure, if a significant amount (i.e., more than 15%) of Tax-Exempt Bond proceeds or any amount of Tax Credit Bond proceeds remain unexpended as of the third anniversary date of the date of issue of the Bonds, the Compliance Officer will confirm with Issuer and Bond Counsel the proper steps to take to protect the qualified status of such Bonds (including but not limited to the continued investment of such amounts) and will confirm with Issuer and Bond Counsel whether the existence of such unspent proceeds impacts the ability of the Issuer to issue any new issue of Tax-Advantaged Bonds for the benefit of the University.

2.2.8 The Compliance Officer will establish such accounting controls, calendars and reporting procedures and such other review procedures as are necessary to confirm the actual expenditure or deemed allocation to expenditure of all bond gross proceeds by the date that is no later than 18 months after the later of the date the expenditure is paid or the date any project that is financed by the Bonds is placed in service. A final record of all actual expenditures or deemed allocations to expenditures must in all events be made by the date that is 60 days after the fifth anniversary date of the issuance of the Bonds or 60 days after the retirement of the Bonds, if earlier.

2.3 Arbitrage Compliance and Yield Restrictions.

2.3.1 The University’s arbitrage rebate consultant will, with information supplied by the University and the Bond Trustee, perform at least every five years on the required anniversary date the required rebate computations to ensure compliance with the Code as outlined in the Tax Certificate. As required by Section 2.4 of this policy, a copy of each arbitrage rebate computation and report will be retained by the University for a period not less than the life of the Bonds plus four years.

2.3.2 The University will not formally or informally create or set-aside funds reasonably expected to be used to pay debt service on Bonds without determining in advance, by consulting with Bond Counsel, whether such funds must be invested at restricted yield, as required by the applicable Bond document.
2.4 Recordkeeping Requirement.

2.4.1 Records Retention. The University will maintain records relating to the Bonds and the use and expenditure of the proceeds thereof, as described in Exhibit 1 attached.

2.4.2 Information regarding investment of the gross proceeds of the Bonds will be retained in the form of all Trustee statements and related materials described in Exhibit 1.

3. REMEDIATION AND VCAP

3.1 In the event that the foregoing procedures reveal a violation or potential violation of any federal tax law requirements, the Office of the General Counsel of the University should be immediately notified in writing and the Office of the General Counsel and, if deemed appropriate, with the advice of expert counsel in the area of Tax-Advantaged Bonds, including, without limitation, Bond Counsel, shall determine if a violation has occurred. If it is determined by the Office of the General Counsel that a violation has occurred, then (1) the Compliance Officer shall inform the Chair of the Budget & Finance Committee and the Chair of the Audit & Compliance Committee and (2) appropriate remedies permitted under the Code shall be pursued, with the assistance of Bond Counsel if required. If action taken under the Code and remedies cannot adequately cure all violations of the requirements of the Code, the Office of the General Counsel shall consult with Bond Counsel and the applicable Issuer of the subject Bonds to timely request, where appropriate, a voluntary closing agreement to address the violation under VCAP, or to otherwise pursue resolution of the matter.

4. REFUNDINGS

4.1 With respect to this compliance topic, the Compliance Officer will coordinate compliance for each issue of refunding Bonds under this policy and the Tax Closing Documentation for each such issue.

4.2 If not already set forth in the tax closing documentation for an issue of refunding Bonds, the Compliance Officer will determine and record the following information and establish the following procedures:

4.2.1 Basic Information.

(a) Determine the list of and redemption dates for all refunded bonds.
### Policies and Procedures

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(b) Determine the list of projects being refinanced with proceeds of the refunding Bonds and any so-called “bad use” or “bad payments” incurred with respect to such Bond-Financed Property.

(c) Determine when all of the bonds refunded with proceeds of the refunding Bonds are actually retired (discharged).

#### 4.2.2 Refunding Procedures.

(a) The Compliance Officer will establish such accounting reporting procedures as are necessary to assure that any refunded bonds are redeemed or retired within 90 days of the date of issue of the refunding Bonds or, if the refunded bonds are not callable within 90 days, that such refunding is permitted under the Tax Closing Documentation or the Regulations and that such call date is the first call date for the refunded bonds required by the Tax Closing Documentation or the Regulations.

(b) The Compliance Officer will apply the same policies and procedures as set forth in sections 2 and 3 of this policy to any refunding Bonds and to the Bond-Financed Property being refinanced by the refunding Bonds.

With respect to this procedure, the Compliance Officer will ensure that any final rebate calculations for the refunded bonds will be performed within 60 days of redemption of refunded bonds and timely filing of Forms 8038-T or Forms 8038-R with such payment as may be required, as appropriate, will be made.

#### 5. MODIFICATION OF BOND TERMS AND EVENTS OF DEFAULT

5.1 With respect to this compliance topic, the Compliance Officer will coordinate compliance for each issue of Bonds under this policy and the Tax Closing Documentation for each such issue.

5.2 If not already set forth in the Tax Closing Documentation for an issue, the Compliance Officer will determine and record the following information and establish the following procedures:

5.2.1 The Compliance Officer will assemble and make all gathered information and documentation regarding the modification of bond terms or events of default parts of the University’s books and records in a form that may be reviewed as necessary by the Issuer.
5.2.2 (a) The Compliance Officer will establish such accounting and reporting procedures as are necessary to confirm that any tax levy, tax credits or other revenues securing the Bonds have been received and that the debt service on such Bonds has been paid and compliance with non-payment covenants with respect to the Bonds has occurred.

In the event that any payment or other type of default occurs, the Compliance Officer will consult with the Issuer and Bond Counsel.

(b) The Compliance Officer will establish such reporting requirements and information gathering procedures as are necessary to identify whether any events have occurred that would have or could have triggered a deemed discharge or reissuance of the Bonds. Such reporting requirements will include assembling prior to execution, if possible, information concerning (i) changes (modifications) of any of the contractual terms of the Bonds (including modifications of the bond interest rates, maturity dates or payment schedule), (ii) changes to the credit enhancement of or liquidity facility for the Bonds, (iii) changes in the nature of the security for the Bonds, (iv) purchase of the Bonds by the Issuer or the University, or (v) any deferral or default of payment of principal and interest due on the Bonds.

With respect to this procedure, Compliance Officer will consult with Issuer and Bond Counsel as to the options that are available to the University for dealing with such events, including acquiring any bond security from a federal agency or instrumentality.
EXHIBIT 1

Record Retention Requirements

I. **Records Retention in General.** The University will retain all records relating to the Bonds and the use and expenditure of the proceeds thereof, as provided in this Exhibit 1.

II. **Records to be Retained.** The types of records to be retained include, but are not limited to, the following:

A. **Transaction Documents.** All legal and closing documents relating to the Bonds, including indentures, loan agreements, trust agreements, resolutions, public notices, Tax Certificates, opinions of counsel (either at closing or subsequently), pricing book or final underwriters’ cash flows, any and all amendments to the foregoing and any and all documents included in the transcript with respect to the Bonds, or amending or subsequently supplementing transcript documents. Transcript items will be preserved by maintaining an electronic (e.g., CD) and/or paper copy of each Bond transcript.

B. **Expenditure of Gross Proceeds.**

1. Documentation evidencing the expenditure of sale and investment proceeds of the Bonds and including any declarations of official intent to reimburse expenditures, projected and actual draw schedules, requisitions, records of compliance with “spend down” requirements, and relevant funds flow memoranda.

2. Documentation evidencing the specific assets financed and refinanced by proceeds of the Bonds including any feasibility studies and including an accounting method for identifying and tracking those assets. See also Section F, below “Use of Bond-Financed Property; Private Security or Payments.”

3. Documentation setting forth all funds and accounts relating to the Bonds, including debt service funds, reserve funds, sinking funds and pledged funds, and any related agreements.

4. Documentation pertaining to the investment of the gross proceeds of the Bonds, including, where applicable, the offering of securities, state and local government series treasury subscriptions, yield calculations for each class of investments, actual investment income received from the investment of proceeds (including gain or loss on sale of investments), guaranteed investment contracts (“GIC”) and evidence of compliance with bidding requirements for any GIC or yield restricted escrow, rebate calculations, credit enhancement, swap transactions, verification reports, float forward agreements, and brokerage and similar fees.

C. **Disposition of Bond Financed Property.** Documentation, if applicable, evidencing the sale or other disposition of the financed property including any records of remediation action and records of any VCAP agreement plan or other settlements with the Internal Revenue Service.

D. **Economic Life Data.** Documentation evidencing the economic life of the assets financed and refinanced with proceeds of the Bonds including any substituted projects.

E. **Allocation.** Documentation evidencing any allocations with respect to the gross proceeds of the Bonds and the accounting method chosen including LIFO, FIFO, direct tracing, or “bond-proceeds spent-first,” including documentation of all elections or allocations.
F. Use of Bond-Financed Property; Private Security or Payments.

1. Documentation evidencing the location, use and ownership of the property financed or refinanced with proceeds of the Bonds, including leases, management contracts, service agreements and other arrangements for the use and ownership of such property; and

2. Documentation evidencing sources of payment or security for the Bonds, including liquidity covenants and negative covenants, mortgages and any related agreements.

G. Use of Bond-Financed Property; Private Use; Sale or Other Disposition; Remediation

1. Documentation evidencing the expenditure of sale and investment proceeds of the Bonds and including any declarations of official intent to reimburse expenditures, projected and actual draw schedules, requisitions, records of compliance with “spend down” requirements, and any funds flow memoranda.

2. Documentation evidencing the specific assets financed or refinanced by proceeds of the Bonds including any feasibility studies and including an accounting method for identifying and tracking those assets. See also Section F, above, “Use of Bond-Financed Property; Private Security or Payments.”

3. Documentation setting forth all funds and accounts relating to the Bonds, including debt service funds, reserve funds, sinking funds and pledged funds, and any related agreements and all post-issuance opinions of Bond Counsel related to the Bonds.

4. (1) Records of private use of the Bond-Financed Property, including sale, lease, non-qualified management or other service contract and non-qualified research contract and (2) any special legal entitlement, any unrelated business activity and any activity that jeopardizes the 501(c)(3) status of the University.

5. Records of all remedial actions and VCAP or other closing arrangements with the Internal Revenue Service.

H. Tax Returns and Related Information. Internal Revenue Service Forms 8038, 8038-T and 8038-R, as applicable and, if relevant, Forms 8328 and 8703, and proof of filing, and information in regard to the pricing of the Bonds, yield calculations, weighted average maturity calculations, other information included in the 8038 statistics report, verification reports and arbitrage rebate reports.

I. Derivatives Contracts. All derivatives contracts, including swap confirmations and copies of swap identification forms (including rate lock contracts), forward contracts and forward float contracts.

J. Other Contracts Affecting Bond Yield. With respect to bond yield, all documents related to qualified guarantees (including insurance policies, guarantees, letters of credit, lines of credit and standby bond purchase agreements), surety bonds, put options and call options with respect to the Bonds, and forms of credit enhancement provided by the University, related or unrelated parties, even if not paid from Bond proceeds.

K. Arbitrage. Documentation evidencing computation of yield, allocation of bond proceeds, compliance with “temporary period” expectations, fair market value purchase (including “bidding” under safe harbor), counsel’s approval of post-issuance credit enhancement or hedging transactions (e.g., bond insurance, letter of credit, interest rate swap, interest rate cap and other similar hedging transactions) and identifying “qualified hedge” contracts.
L. **Investment of Bond Proceeds.** Documentation pertaining to the investment of the gross proceeds of the Bonds, including the offering of securities, subscriptions for United States Treasury Series, State and Local Government Series, if any, yield calculations for each class of investments, actual investment income received from the investment of proceeds (including gain or loss on sale of investments), guaranteed investment contracts (“GIC”) and evidence of compliance with bidding requirements for any GIC or yield restricted escrow, rebate calculations, credit enhancement, swap transactions, verification reports, float forward agreements, and brokerage and similar fees.

M. **Bond-specific Documentation.**

1. **Capital Cost 501(c)(3) Bonds.** Documentation evidencing compliance with the expenditure of 95% of “net proceeds” on capital costs.

2. **Elections and Allocations.** Documentation, if applicable, evidencing (a) elections made with respect to the Bonds including multi-purpose allocations, election to treat a portion as a construction issue exempt from rebate, election to apply transition (grandfather) rules or to apply proposed or temporary regulations or to elect into regulations which are not otherwise applicable to the Bonds, (b) agreements and assignments between governmental units that affect volume cap allocations under the Code and (c) any election not to take depreciation on leased property that must be treated as owned by a government unit.

N. **Safe Harbor.** Documentation evidencing compliance with the safe harbor bidding procedure for investment contracts and defeasance escrows.

O. **Nonpurpose Investments.** With respect to nonpurpose investments deposited into or held in any fund or account in connection with the Bonds, the following information will be recorded and retained:

1. Purchase date;
2. Purchase price;
3. Information establishing that the purchase price is the fair market value as of the acquisition date (e.g., the published quoted bid by a dealer in such an investment on the date of purchase);
4. Any accrued interest paid;
5. Face amount;
6. Coupon rate;
7. Schedule of interest payments;
8. Disposition price;
9. Any accrued interest received; and
10. Disposition date.
P. **Rebate Payments.** Documentation evidencing Rebate Payments (except as otherwise provided in the Tax Certificate, first installment due on the fifth anniversary of the Bonds plus 60 days, with additional installments every five years and a final installment 60 days after retirement (or redemption)) of the Bonds.

III. **Records Retention Format and Periods.**

A. **Record Format.** All records must be kept either in hard copy or electronic format allowing for complete access during the applicable period (generally ending four years after all of the Bonds are redeemed or paid at final maturity, as applicable). Electronic records shall comply with the requirements of the Code. Electronic record retention must also retain the machine(s) or other retrieval system that indexes, stores, preserves, retrieves and reproduces all transferred information, and provides adequate cross-referencing with the University’s books and records.

B. **Required Retention Periods.** The University will use its best efforts to retain records until four years following the final redemption or final maturity date of the Bonds, as applicable.
PURPOSE

It is the policy of Creighton University to offer donors the opportunity to name proposed and existing buildings, facilities, and areas or parts thereof in exchange for a qualifying contribution. The purpose of this policy is to provide guidance for management in soliciting donor support for capital projects that include naming rights. The University’s Board of Trustees has discretion to approve naming gifts outside of these guidelines.

POLICY

Funding a capital project is formally opened through execution of a signed gift agreement. The gift agreement reflects the donor’s promise to contribute a stated amount, the donor’s wishes concerning the use of the gift, and provides assurance that the gift will be used in accordance with the donor’s wishes.

I. Building Support

The University will consider naming new or existing facilities in honor of those whose gifts have had an extraordinary impact on the University. This recognition is a powerful affirmation of the donor’s partnership with the University’s mission. Any proposal to name a facility must have prior approval of the President before discussion with the potential donor, and is ultimately subject to approval by the Board of Trustees.

The following guidelines must be met for a naming opportunity to be offered to a donor for a structure.

- For new construction, the gift must be not less than 50 percent of total project costs and must include an additional gift to create an endowment that will support not less than 10 percent of the anticipated annual operating costs of the new facility. The required operating cost endowment will be determined in consultation with Facilities Management and using the established University endowment distribution formula.
- For renovation of an existing structure, the gift must not be less than 35 percent of the total project costs. There is no requirement for an operating endowment provided the renovation does not materially increase operating costs.
- For an existing structure with no related construction, the gift must be not less than 35 percent of replacement value of the structure. There is no requirement for an operating endowment.
- The University recognizes that some University owned buildings generate a clearly defined revenue stream that can be used to reduce the cost of construction and/or the ongoing operational costs associated with the building; for example, residence halls, research facilities and medical clinics. The Board of Trustees reserves the right to reduce the minimum amount required from a donor to name a building that has a clearly defined revenue stream, but in no event will the minimum be less than 35% of total project costs. A separate endowment for the operational support of the building shall remain a required component for the naming rights opportunity.
II. Financial Considerations Associated with Capital Projects.

The University is aware that the costs associated with renovation of existing facilities and the costs associated with the construction of new facilities have a direct impact on University budget and an indirect cost to the University’s most prized asset, its students, through the possibility of higher tuition and fees needed to offset these costs. In order to minimize these financial costs and their potential negative impact to the students the following guidelines must be met for a naming opportunity to be offered to a donor for a structure.

- The construction project must be approved by the Board of Trustees through the University’s established capital project approval process.
- Prior to the public announcement of the University’s intent to construct and/or renovate a building the University shall have received a written funding commitment from the Naming Donor consistent with these policies.
- Prior to ground breaking and/or commencement of construction the University shall have received written pledges representing 100% of total project costs.
- Prior to ground breaking and/or commencement of construction the University shall have received from the Naming Donor an amount equal to not less than 50-100% of the anticipated total project costs; and, shall have also received 50-100% toward the funding of the operational endowment for the building. The specific percentage shall be at the discretion of the Board.
- Written funding commitments from the Naming Donor shall be for a term of years not more than the anticipated time for the completion of the construction and/or renovation of the facility; and, shall be secured by a binding commitment from the Naming Donor’s estate.

III. Administrative/Commemorative Temporary Naming

Any proposal to temporarily name a building or an area within an existing building to commemorate an individual for his or her loyalty, dedication, and/or service to the University must have prior approval of the President before discussing with the honoree or the family of the honoree; and, is subject to approval by the Board of Trustees. All buildings or areas within an existing building temporarily named pursuant to this paragraph may, upon approval by the Board of Trustees, be renamed should a subsequent donor make a qualifying contribution as set forth above, for the naming of an existing building or area within an existing building.

Removal of Names

Given the perpetual nature of the University, it is likely that a named building or area within an existing building will someday be either demolished or substantially remodeled to improve its function and/or to create a completely new use of the space. All donors to the University should be made aware of this possibility. Should such an event occur, the University will review the circumstances and attempt to find a way to recognize the donor in a way that is consistent with his or her original intent.
In the event a named building or area within an existing building is destroyed by fire or an act of God, the University is not required to rebuild the building or area within an existing building. However, if the University uses insurance proceeds to reconstruct the building or area within an existing building and the proceeds exceed 66 percent of said expense, then the University shall maintain the name of the donor on the building or area within an existing building.

The University reserves the right to remove the name of a donor from a building or area within an existing building if the donor fails to honor his/her financial commitment associated with the naming rights or has engaged in conduct that besmirs the reputation and goodwill of the University. Said removal shall be by a majority vote of the Board of Trustees.

**Inventory and Signage**
The Office of Donor Relations in the Division of University Relations is charged with maintaining an inventory of naming opportunities and working in cooperation with Facilities Management to design and install donor naming-related signage consistent with established campus design standards.

**PROCEDURE**

I. **Naming New Facilities: 50 percent of total project costs plus an endowment that will support 10 percent of the annual operating costs of the facility**

Deferred gift commitments will not be counted toward either minimum requirement, unless full funding from other sources is available for construction and the endowment.

II. **Renovation of Existing Facilities: 35 percent of the budgeted total renovation project costs**

Renovations to an existing facility may be named by a donor with a gift in an amount equaling 35 percent or more of the budgeted total renovation project costs.

III. **Naming Existing Facilities: 35 percent of replacement value**

Existing facilities may be named by a donor with a gift equaling 35 percent or more of the replacement cost of the facility. A donor with a deferred gift commitment may name existing facilities, but only the present value of the deferred gift commitment will be counted toward the minimum and the deferred gift must be irrevocable.

IV. **Naming Areas Within Buildings: Determined on a case by case basis**

Naming opportunities for labs, lecture halls, seminar rooms, etc. in new construction will be determined as the design and construction work allow and will be priced in accordance with other naming opportunities existing within the structure.
Naming opportunities for labs, lecture halls, seminar rooms, etc. in renovated structures will be developed as campaign needs are refined and will be priced in accordance with other naming opportunities within the existing structure.

Required gift levels for naming defined areas of any building, i.e., labs, lecture halls, seminar rooms, etc., will be recommended to the President by the Vice President for University Relations in consultation with the Dean(s) or other senior administrator whose program occupies the space. Minimum gift levels will take into consideration the visibility of the defined area, the nature of the activity housed in the named area, the attractiveness and location of the area, and an evaluation of the cost of building or replacing the space to be named.

AMENDMENTS OR TERMINATION OF POLICY

The University reserves the right to modify, amend or terminate this policy at any time.
INTRODUCTION

Educational activities of universities are commonly carried out through departments. Circumstances may exist in which the departmental organizational structure is not the optimal mode of organizing university activity for the conduct of research, the provision of professional services, or the support of interdisciplinary teaching. When such research, service, or teaching activities acquire a scale and scope beyond that of existing academic units, the University may establish non-departmental organizational units. The term "institute" will be applied to such units. This document is University policy on such institutes.

INTENT OF THIS POLICY

This policy is intended to accomplish the following: (1) to establish guidelines for creating new institutes at Creighton; (2) to establish guidelines for periodic review of the effectiveness of institutes, with mechanisms for recognizing and rewarding exemplary efforts, as well as for terminating institutes that have outlived their appropriate functions; (3) to establish administrative procedures and reporting procedures for institutes; and (4) to establish a framework which will regulate Creighton's support of institutes.

DEFINITION

An institute is an academic unit that involves faculty members, other scholars and students in research, service or interdisciplinary instruction. The institute's activities may be supported by additional personnel. The institute will usually have interests and activities which cross departmental or school boundaries, but may be a unit within a department when it is of a size or scope that exceeds the requirements of a normal department.

AUTHORITY

Institutes shall be established by the President. Administration of institutes is delegated by the President to the appropriate Academic Vice President, and may be further delegated. No institute may be established until review as herein prescribed has been completed, nor may an institute be continued without periodic review. The Vice President concerned shall report to the President all major reorganizations affecting institutes.
Policies and Procedures

SECTION: Academic Concerns

CHAPTER: General

POLICY: Institutes Policy

ADMISTRATION

The chief officer of an institute, the Director, is appointed by the appropriate Vice President. Rules governing the establishment, approval, funding, operation, and review of the institutes; appointment and review of directors; personnel matters; and all policies and procedures relating to institutes, shall be issued by the President after consultation as outlined in the Administrative Procedures section.

PURPOSE

Institutes are established to contribute to the mission and goals of the University and, in particular, should provide a significant opportunity to advance the scholarly, scientific, artistic, professional, or technological aspects of important fields. They must provide students with added research, clinical instruction, or other learning opportunities, facilities, and assistance. They should strengthen interdisciplinary programs of research, teaching, and service conducted by the faculty, explore opportunities lying outside traditional departments, or expand an operation beyond the scope or scale of existing departments.

SCOPE

An institute will usually be interdisciplinary in scope, involving the faculty and students of two or more departments. An institute may, however, be established if the scope and objectives of its research, service, or instruction exceed those of a normal, fully staffed and balanced department, or if special opportunities to create or strengthen collaborative activities exist. An institute is expected to provide opportunities for the participation of students in its activities.

FUNDING

The activities of an institute may be funded by internal budgetary allocations, by extramural funds sought for that purpose, or both.

APPOINTMENTS IN INSTITUTES

Participants in an institute may have their principle University appointment in the institute or in other academic units of the University. An institute may not, however, recommend or confer the titles Assistant or Associate Professor or Professor, although persons holding such title by virtue of other University appointments may be compensated by the institute for that portion of their effort devoted to the institute.
Other specific titles, annual review procedures, and promotion standards or institute personnel shall be designated and used uniformly in institutes throughout the University.

**ADMINISTRATIVE PROCEDURES**

**DEFINITION AND PURPOSES**

1. An institute is an academic unit of the University established to carry out the mission and goals of the University in accord with these policies. An institute may not have sole jurisdiction over courses and curricula and cannot offer courses for credit toward a degree without co-sponsorship by a department. An institute may not separately admit graduate or undergraduate students, nor may it function independently of other schools or colleges as a degree-granting unit of the University. However, an institute may perform other academic functions ordinarily carried on by departments, e.g., organize research conferences and meetings, advise on curricula, help professors provide guidance for students, and manage interdisciplinary instruction.

2. An institute shall be identified as an institute only when it has been approved as such by the President. It is important to distinguish between formally established institutes and research projects of a less formal character. In the solicitation of extramural funds for a research project that has not been proposed, reviewed, and approved for institute status, care should be taken not to use terminology nor to make representations which suggest that the project is in fact a University-approved institute or is about to become one.

**LINES OF RESPONSIBILITY**

3. An institute shall be headed by a Director who is administratively responsible to the appropriate Academic Vice President or, by his delegation, to an academic officer such as a dean of a school or college. The extent to which the institute is interdisciplinary and has activities which cross school lines shall influence the delegation of reporting authority.

**ADMINISTRATION, BUDGETARY SUPPORT, PERSONNEL**

4. Usual University budgetary process and procedures will apply to institutes, just as they do to departments and schools or colleges.
PROCEDURE TO ESTABLISH AN INSTITUTE

5. Certain procedures must be followed to establish a new institute. The primary function of these procedures is three-fold: (1) to ensure that a full measure of consultation with all concerned elements of the University has occurred, (2) to ensure that the proposal has merit, and (3) to ensure that the proposal does not conflict with the mission and goals of the University.

Written proposals requesting the establishment of a new institute may originate with any element of the University.

The proposal shall contain at least the following:

a. A description of the purpose of the institute and the knowledge, service, and/or instruction that the institute may be expected to contribute;

b. A description of the extent to which the proposed institute would duplicate the work of other institutes and departments of the University;

c. A description of similar organizations at other universities;

d. Names of faculty members who are interested in participating in the institute's activities;

e. A statement about anticipated effects of the proposed institute on the teaching programs of the participating faculty members' departments;

f. Projections of numbers of faculty members and students, research appointees, and other personnel;

g. Budget estimates for the first year of operation and projections for following years;

h. Sources of funding, relationships between the members of the institute and the funding source, and any restrictions imposed by these sources;

i. A statement about immediate space needs and realistic projections of future space needs;

j. A statement of other needs such as capital equipment and library resources.
Policies and Procedures

SECTION: Academic Concerns

CHAPTER: General

POLICY: Institutes Policy

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6. Such proposals shall be submitted through the appropriate dean or deans to the appropriate Academic Vice President, who will organize an ad hoc review of administrative aspects of the proposal. This review will include the comments and recommendations of the involved deans. At his discretion, the Vice President may find it effective to consult with other sectors within the institution. This review shall be assembled from these various sources by the Vice President and forwarded by him with his own recommendation to the President. The review shall pay particular attention to the following matters:

   a. That space and University resources sufficient to meet the projected needs of the institute can be reasonably expected to exist;

   b. That the source and solicitation of funding has been considered within the context of the University's overall interests;

   c. That the purposes to be served are consistent with the mission, goals, needs, and priorities of the University and do not inappropriately duplicate existing programs;

   d. That assurances exist that no donor or grantor shall have control over a program or project beyond that implied by mutually agreed-upon requirements for financial accountability and reporting;

   e. That no conditions are attached to any gift, grant, or contract that would in any way jeopardize the University's commitment to the principles of academic freedom, nondiscrimination, and the free dissemination of research results;

   f. That all appointments are made in accord with established University procedures.

At this same time the Vice President shall also organize a review of the academic aspects of the proposal. For this purpose he shall gather an ad hoc group knowledgeable in the general areas related to the proposed institute. This ad hoc group shall prepare a written report to the Vice President paying particular attention to the following matters:

   a. That the proposed institute is an academically worthy one, consistent with the mission of the University, and expected to be in a potentially competitive position; and

   b. That the proposed institute conforms to the Purposes as outlined herein.

It is also important that the larger University community be aware of the proposed creation of such new institutes. Therefore, at a timely point in the review of request for new institutes, the Vice President shall formally inform the following bodies that the creation of a new unit is under study:
### Policies and Procedures

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**POLICY:**

Institutes Policy

1) The other Vice Presidents;
2) The Council of Deans;
3) The Academic Council.

The proposal, the administrative review, the ad hoc review by experts, and other information that may be gathered form the basis for the recommendations of the Vice President to the President.

### PROCEDURES FOR APPOINTING A DIRECTOR

7. The Director of an institute is appointed by the Vice President after consultation with the members or prospective members of the institute, appropriate faculty members, and the administrative officer(s) to whom the Director will report, and where appropriate, on the recommendation and with the concurrence of the appropriate dean or deans.

### PROCEDURE FOR REVIEW OF INSTITUTES

8. The Vice President shall conduct a review of each institute at intervals of five years or less. In conducting this review, the Vice President shall seek the advice of an ad hoc committee of persons familiar with the academic areas within which the institute works, and of the administrative officer to whom it reports.

A major basis for reviewing institutes shall be examination of documents routinely prepared by the institute in the course of its usual activities, such as final reports to sponsors and/or annual documents submitted to the University as part of the budget process. Normally, review of such documents shall precede other more demanding information-gathering activities, if the latter are, in the judgments of the reviewers, needed at all. The first review of an existing institute shall be sufficiently extensive so that the resulting review reports conform roughly to the requirements specified for pre-establishment review of a new institute. At the discretion of the reviewing committee, subsequent reviews may be less extensive. Each review shall make a recommendation about the institute's establishment or continuance; it may also suggest changes.

The review committee shall transmit its report and recommendations to the Vice President, with copies to the Director of the institute and to the administrative officer to whom the institute reports. Each of the latter may, if they wish, transmit written comments on the review and recommendation to the Vice President. If, in the Vice President's judgment, circumstances warrant discontinuance of the institute, such discontinuance is referred to the President for final action.
9. When a decision is made to discontinue an institute, sufficient time should be provided to insure an orderly termination or transfer of contractual obligations and other programs. Discontinuance of an institute shall take place through phased reductions in program activities and in such University support as may exist, over a period not normally to exceed one year from the date of decision by the President to discontinue.

10. The effectiveness of each Director shall likewise be reviewed at intervals of five years or less, preferably at the time the institute is being reviewed, following the same procedure as for the institute review. If the institute is to be continued, the decision whether to continue the appointment of the Director is made by the Vice President.

REPORTS

11. Annually, each institute shall submit a report to the officer to whom it is responsible, with copies for the Vice President. This report shall include:
   
a. Information deemed relevant to the evaluation of an institute's effectiveness, including research, service and/or teaching accomplishments and projection of plans;

b. Number of faculty members engaged in the institute's program or its supervision;

c. Numbers and FTE's of professional, technical, administrative, and clerical personnel employed;

d. List of publications by the institute's staff;

e. Sources and amounts (on an annual basis) of support funds;

f. Expenditures;

g. Description and amount of space currently occupied;

h. Numbers of students at all levels involved in the institute's work, and descriptions of their participation.
**PURPOSE**

The purpose of this policy is to describe the principles and processes designed to ensure quality in distance education at Creighton University and to establish distance education as an effective method for extending educational opportunities within Creighton's mission as a Catholic, Jesuit University committed to excellence.

**POLICY**

**Mission:** Institutional decisions made to offer distance courses or programs must explain how offering the distance courses or programs is consistent with the mission of the University and clearly identify the populations being served by the distance educational offerings. Significant differences in populations served by distance programming and those served by the face-to-face courses and programs must be supported by a documented, intentional academic plan to reach different populations.

**Organizational Structures:**

The Distance Education Executive Committee membership is appointed by the Provost to guide the work of CeLAI and is charged with:

- Articulating and defining the vision for distance education at Creighton
- Providing leadership for coordination of support for distance programming
- Developing policies and procedures, and establishing distance education goals to advance the University’s distance education programming.

The Distance Education Executive Committee membership shall consist of:

- Lead administrator for CeLAI (chair)
- 2 Directors of distance education programs
- Dean of the Graduate School and College of Professional Studies
- Lead administrator from the Office of Assessment
- Representation from the Office of Finance
- Representation from Marketing and Communications
- Representation from Enrollment Management
- Representation from DoIT

The Distance Education Advisory Council includes representatives of each school or college, areas directly involved in supporting distance students, and student representatives. The Council will be advisory to the Distance Education Executive Committee.
The Council will:

- Represent students, faculty members, and support units in matters pertaining to distance education and technology integration by bringing forth issues, concerns, and questions to members of the Distance Education Executive Committee.
- Provide information (i.e., fact gathering, surveys) as necessary to assess distance education growth and quality.
- Participate on sub-groups when certain projects/topics need to be explored.

The University is accountable to the Higher Learning Commission (HLC) and the public for evidence of quality in distance education programming. The Center for eLearning and Academic Innovation (CeLAI) is established as the University’s central organizing and reporting agency for evidence of quality in distance education. The CeLAI, Distance Education Executive Committee and Advisory Council, in conjunction with academic administrators, are therefore responsible for establishing procedures to evaluate quality of distance education programming at the University.

INSTITUTIONAL SUPPORT

**Academic Planning:** Documented strategic planning for distance programs and courses must include evidence of market viability for the program, targets for enrollment, academic and student services, course development, faculty support, infrastructure and sustainability. In addition to other requirements and procedures in place for on-ground courses and programs, before schools and colleges begin to develop distance education programs or courses they must consult with the CeLAI. The CeLAI must be notified of all face-to-face programs or courses that are revised such that they become distance programs or courses and must subsequently comply with all aspects of this policy.

The University’s Approval of a new Academic Program policy (4.1.4) will be used to review new distance program proposals.

Proposals to translate an existing face-to-face program to a distance education format will be reviewed by the Distance Education Executive Committee. The Committee has final approval authority for proposals to translate an existing face-to-face program to a distance education format. Proposals must use the New Distance Education Program: Translation of On-Ground proposal template and be submitted to CeLAI no later than 6 months prior to the proposed program initiation date. The purpose of this review is to ensure that the program is meeting the quality standards set forth for distance education.

CeLAI is available to assist with proposal development for both new and translated programs and will work with the unit developing the proposal to conduct a preliminary review of the proposal to help streamline passage of the proposal.
Technology Infrastructure: The University must provide reliable and sustainable technology infrastructure and support needed to deliver distance education. A documented technology plan that includes electronic security measures (i.e., password protection, encryption, back-up systems), plans for maintaining and upgrading the technology infrastructure that supports distance education must be in place and operational.

CURRICULUM AND INSTRUCTION

Curricula and Course Development: Procedures for approval of distance education curricula must be the same as those for curricula offered face-to-face. Oversight of the curricula for distance courses or programs is the responsibility of the faculty within the academic unit offering distance courses or programs. Distance programs must have a schedule of course offerings available to students allowing them to plan their academic program of study. A course development schedule for distance programs must be in place to ensure distance courses are ready to be offered in alignment with the published program of study. Learning goals for distance education programs must be defined and be publicly available.

Course Design: The design of distance courses must align with the University’s established best practices for distance course design as defined in the Online Course Design Rubric located on the CeLaI web site. Course design review will be conducted by the CeLaI for all new distance courses. Course design review using the University Online Course Design Rubric will be conducted every five years for existing distance courses.

Student Identity Verification: Distance courses and programs must employ the University’s established processes for verification of distance student identity. Student identity verification requirements are established to assure compliance with regulations promulgated by the HCL. Pursuant to the Higher Education Opportunity Act of 2008 and subsequent HLC regulations, each distance student is issued a unique username and password. These credentials are used to access distance course content and assessments of learning. Initial verification of student identity occurs during the program admission processes.

Given the dynamic nature of student verification regulations, the Student Identity Verification portion of this policy will be reviewed annually and modified if needed.

Distance students must be made aware of and held accountable to the same academic integrity standards as on-campus Creighton students. These standards are articulated in the Code of Conduct and the Academic Honesty Policy from the Creighton University Student Handbook and the relevant University Bulletin. Exams that are not open book must either be timed such that in order to successfully complete the exam students would not have time to use reference materials to obtain answers, or employ a proctor using a testing center or other proctoring arrangement approved by the academic program. Faculty will apply the same or similar techniques to detect academic dishonesty for distance and on-campus students.
**FACULTY SUPPORT**

**Faculty Support:** Faculty support resources are coordinated by the CeLAI, which serves as a central resource for all Creighton faculty members teaching distance courses or in distance programs. Developmental activities to prepare and support all faculty members and instructors (full-time, part-time, adjunct, contributed service, etc.) for teaching distance courses or programs (including teaching, learning, technology, assessment practices and the incorporation of these practices into courses) must be routinely available and all faculty members are encouraged to use them. Instructional design and technical assistance in distance course development, delivery, and revision must be available to all faculty members teaching distance courses. Faculty members developing new distance education courses or making significant revisions to existing distance education courses will work with an instructional designer throughout the development process.

**Distance Teaching Preparation:** All faculty members new to teaching distance courses for Creighton University must successfully complete the Creighton University certification for distance teaching and learning. All faculty members teaching distance courses must demonstrate distance teaching competencies. The evidence required to demonstrate achievement of the competencies is determined by the Distance Education Executive Board.

**STUDENT AND ACADEMIC SERVICES**

**Prospective Students:** Prospective students of a distance program must be provided self-assessment opportunities to determine their skills and aptitude for distance learning. Prospective students must also be provided a description of technology requirements, distance or technology fees, exam proctoring requirements, equipment needed, onsite visits required, contact information for an advisor, and overview of the structure of a distance course.

**Access to Student Services:** Distance students will have adequate access to the range of services appropriate to support the programs offered through distance education. Technical support for distance students must be available from a distance, and a means of communicating emergency and planned outages that will affect distance students must be in place. The CeLAI serves as the point of contact for distance students needing assistance in securing access to support services for students. Feedback mechanisms must be regularly employed to assess effectiveness of all support systems for distance students.

**Orientation:** Orientation to support services for distance students, including access to and training for the library resources, must be provided to all distance students.

**EVALUATION AND ASSESSMENT**

**Assessment Plans:** All distance programs must have assessment plans that are congruent with the program learning goals and align with the Creighton University policies on assessment and/or program review.
Parity of Distance and On-Campus Courses and Programs: To ensure similarity of outcomes of programs taught using different delivery methods, programs taught in the traditional face-to-face format and in the distance format must be reviewed annually by the academic unit offering the program using the University defined parity metrics. The outcomes of such review will be reported annually to the CeLAI.

Assessment of Program Quality: Each academic program is responsible for assessment of program quality including periodic review and updating of distance course materials. The course materials review schedule is defined by the academic unit offering the distance program. The University’s standard set of course evaluation questions for distance courses must be integrated into distance course evaluation tools used by the academic unit offering the distance courses or program.

The CeLAI will collect assessment data annually from distance program directors or course instructor of record and will then generate an annual report of distance programming quality. The report will be submitted to the University Assessment Committee and the Office of the Provost.

SCOPE

This policy applies to all University distance education courses and programs as defined in the DEFINITIONS section of this policy.

ADMINISTRATION AND INTERPRETATION

This policy is administered by the Office of Provost. Questions regarding this policy should be referred to this office.

DEFINITIONS

This policy employs the Higher Learning Commission’s definition for distance programs and courses. Distance-delivered programs are those certificate or degree programs in which 50% or more of the required courses may be taken as distance-delivered courses. A program is defined as a distance delivered program if a student may matriculate through a program by taking 50 percent or more of the required course work in a distance education format. In other words, if the program includes a number of required courses offered at in a distance education format and a student may choose to take the distance required courses as part of her/his program of study, and by doing so s/he earns 50 percent or more of the program’s required credits in the distance education format, then the program is identified as a distance delivered program.

Distance education courses as those in which all or the vast majority (75% or more) of the instruction and interaction occurs via electronic communication or equivalent mechanisms, with the faculty and students physically separated from each other. The academic unit sponsoring the course or program will use the HLC definitions to determine if a program or course falls within the purview of this policy.
For the purposes of this policy the term ‘faculty member’ includes all individuals performing instructional activities in a course.

**AMENDMENTS OR TERMINATION OF THIS POLICY**

The University reserves the right to modify, amend, or terminate this policy at any time. The policy is not a contract between Creighton University and its employees.
Policies and Procedures

SECTION: Academic Concerns

CHAPTER: General

POLICY: Calculating Last Date of Attendance in Distance Education Courses

PURPOSE

The purpose of this policy is to describe the processes for calculating last date of attendance in distance education courses in order to comply with 34 CFR § 668.22 which governs the determination of the amount of Title IV grant or loan assistance that must be returned to the federal government upon a student’s withdrawal from a course.

SCOPE

This policy pertains to any distance education course as defined in the “Quality in Distance Education Programs Policy” (No. 4.1.2).

ADMINISTRATION

The degree-granting unit, in consultation with program administration, is responsible for calculating a student’s last date of attendance in a distance education course. A student’s last date of attendance shall be calculated by determining the last date that a student engaged in an academically meaningful activity within a distance education course, including, but not limited to:

1. Submitting an academic assignment in a drop box;
2. Posting in an online discussion board about academic matters;
3. Taking an exam, an interactive tutorial, or computer-assisted instruction;
4. Sending a course email message to a faculty member pertaining to the academic subject studied in the distance education course.

Documentation of a student’s last day of attendance in a distance education course must accompany the request to withdraw the student from a distance course. Examples of documentation include, but are not limited to:

1. A report generated from the learning management system, the report must document the date of the student’s academically meaningful activity;
2. Copy of an email message to a course instructor containing academically meaningful activity, the email must include the date it was sent;
3. A report generated from an electronic exam system used to administer exams or quizzes for the course, the report must document the date of the student’s exam or quiz;
4. A report generated from an application used within the course demonstrating student engagement in academically meaningful activity, the report must document the date of the student’s academically meaningful activity.
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**POLICY:**

Calculating Last Date of Attendance in Distance Education Courses

Examples of online activity that should *not* be taken into account as the only means for calculating last date of attendance include, but are not limited to:

1. Accessing discussion boards without posting;
2. Logging into the course management system;
3. Posting in an online discussion board about non-academic matters (e.g. a board intended for students to introduce themselves to the other course members).

**ADMINISTRATION**

This policy is administered by the Office of the Vice President for Academic Affairs. Questions regarding this policy should be referred to this office.

**AMENDMENTS OR TERMINATION OF THIS POLICY**

The University reserves the right to modify, amend, or terminate this policy at any time. The policy is not a contract between Creighton University and its employees.
**Policies and Procedures**

**SECTION:**
Academic Concerns

**NO.**
4.1.4.

**CHAPTER:**
General

**ISSUED:**
11/15/12

**POLICY:**
Approval of a New Academic Program

**PURPOSE**

This policy outlines the procedures, structure and approval requirements for new academic programs.

**POLICY**

The new program approval policy and procedures provide a rational and effective process for program development, consideration and approval that will ensure that the University is making coordinated decisions for program development, resource allocation, and external regulatory compliance. This document provides a structure to assist in the planning and approval process of new academic degree programs at Creighton University. By requiring specific data and background information, the procedures are intended to ensure appropriate consistency and care in designing and presenting new academic program proposals. They are also intended to clarify the institutional procedures that govern internal and external approvals and thereby eliminate confusion and unnecessary delays.

This policy and accompanying procedures govern all proposed new academic programs and new degrees at Creighton University. The process also pertains to changes in format of delivery and to changes which have implications for one or more of the other Colleges. Whenever the phrase “new academic program” is used in this document, it refers to one or more of the foregoing categories.

**DEFINITIONS**

Guidelines for Developing and Seeking Approval of New Academic Programs, Pre-Proposal Screening Document – Refer to Appendix A

New Academic Program Full Proposal Development – Refer to Appendix B

**PROCEDURE**

**Academic Governance and Review of Proposals**

**PHASE 1:** College/School(s) Planning

**Pre-proposal:** Initial steps for program planning and approval begin at the level of the College or School that will provide the primary program content. Because the responsibility for curriculum belongs to the faculty, it is essential that faculty members in the discipline(s) are involved in the planning and execution of a curriculum leading to a new degree.
All planning should be in concert with the Dean of the School or College(s) who will be responsible for providing resources for the new program. Initial planning should be done by developing a pre-proposal and using screening questions regarding the viability of such a program. (See Appendix A - Pre-proposal Guidelines)

There should be an initial School(s) review of the pre-proposal and approval to develop a full proposal. The pre-proposal should be discussed by the Dean(s) and Provost (or his or her designee).

**PHASE 2:  Formal FULL Proposal Development and Internal Unit Approval**

**Program Proposal:** The second step in the process is the development and evaluation of a full program proposal that includes the fiscal impact of such a program which should include a five year pro forma budget. (Appendix B - Proposal Guidelines) The Dean discusses this with the Provost or his or her designee, who in turn discusses it with the President. If the fiscal impact is acceptable to the Provost and the President, the proposal may proceed to the next step.

**School or College Review:** The third step in the approval process is the evaluation of the full proposal by the School or College review committee or governing board. For example, the Graduate Board evaluates the proposal based on graduate policy related to such items as admission criteria and comprehensive examinations. In addition, the Board is concerned with whether the program will be able to recruit and retain qualified students in sufficient numbers to provide a critical mass and adequate interaction. While content is not generally examined in terms of specific disciplinary elements, the Graduate Board does attempt to determine whether there is a sufficient theoretical base in the discipline to provide for substantive content at a level befitting graduate study. Program goals must be explicitly stated and a plan for assessment must be present. The assessment plan for all new programs will be reviewed by the Associate Vice President for Academic Excellence and Assessment and concerns must be addressed.

**PHASE 3: University Review and Approval**

**Academic Planning Review (APR):** Once a new academic program proposal is approved by the respective School or College’s academic governance body, it proceeds to the University Academic Planning Review. The APR is charged with supporting the President in ensuring sound academic program development and maintaining programmatic excellence throughout the University. The APR reviews the proposal and makes a recommendation by majority vote to the President to approve, modify, or reject the proposal.
The Provost or his or her designee will assemble and chair an executive committee that includes appropriate academic representation for the proposal being reviewed, representation from academic administration, finance, assessment, libraries and institutional accreditation. The APR committee will review the proposal, school or college recommendation and any other accompanying materials. The APR will make recommendations to the President for prioritization of implementation as part of the University’s academic plan.

Recommendations include:
- Approval
- Pending approval once specific recommendations for change and/or follow up
- Reject

AMENDMENTS OR TERMINATION OF POLICY

The University reserves the right to modify, amend or terminate this policy at any time.
GUIDELINES FOR DEVELOPING AND SEEKING APPROVAL
OF NEW ACADEMIC PROGRAMS

Pre-Proposal Screening Document

INTRODUCTION:
New program development is critical to the University and both encouraged and expected. New programs refer to any new degree program, graduate certificate program, or doctoral minors. These guidelines are intended to be helpful in the planning and implementation of new programs.

INITIAL PLANNING

STEP 1: Idea Generation
Idea generation for a new program can come from many sources. They may come from competing institutions, market needs, societal or community needs or individual/administrator or donor ideas.

STEP 2: Program Concept Pre-Proposal – Screening Questions
While there could be new program development in several areas, resources are limited at most institutions. A screening process is an important step before moving forward with development of a full program proposal. The following questions are meant to provide initial screening of the viability of new programs:

1) Will the proposed program contribute positively to the mission of Creighton University?
2) Can this program be delivered with sufficient academic quality at Creighton?
3) Will the program meet direct costs and/or be profitable?
4) Is the program consistent with the strengths of the department(s) and/or School?
5) Will the program require a substantive change report and possible visit from Creighton’s institutional accrediting agency, the Higher Learning Commission?
6) Is this program sustainable on a long term basis?
7) Are there any program delivery formats that would be new or different?
8) Is the program similar to any other program on campus?
9) Are there characteristics that distinguish this program from other programs offered by competing institutions?

If the answer to these questions (1-4,6,9) is yes, then developing a short concept proposal may be in order.

STEP 3: New Program Pre-Proposal/Concept Paper
The next step stems from the answers to the screening questions. These should be summarized in a short pre-proposal that also includes a new program concept description (3 to 5 pages). This concept description should be shared with the Dean and Provost or designee in the area for approval of the “concept.”

Key elements to address:

1) Provide a brief justification for why Creighton needs this program and why Creighton should offer the program.
2) Provide a brief description of whether and why students will enroll in the program.
3) Estimate start-up costs for the program and indicate possible funding sources.
4) Facilities -If additional facilities are needed, how they will be acquired.
5) Curriculum and delivery: Are there special characteristics of the curriculum (as compared to similar programs)? Will the program be attractive to under-served populations?
6) If there are similar programs in your service area, how will the proposed program affect them?
7) Do you plan a collaborative arrangement with other departments or another institution or entity?

Once the Pre-Proposal/Concept paper has been approved by the Dean and the Provost or designee, the department(s)/units will be invited to submit a Formal Proposal.
APPENDIX B
NEW ACADEMIC PROGRAM
FULL PROPOSAL DEVELOPMENT

The formal program proposal should contain the following components:

1. **Program Description**

2. **Justification/Rationale for Program/Link to Jesuit institution/educational philosophy**

   This section should include a description of the “history” of the idea and the planning process that led to the proposal. It should confirm that there is an unmet need and demand for the proposed program and that the proposal is likely to attract and maintain a sufficient number of enrolled, tuition-paying students to be financially viable. Data to support the need should include statistics and opinions by authorities about the external environment generally and about educational needs that Creighton University would meet by offering the program. Ideally, statistics should reflect both the current environment as well as the projected future environment.

3. **Market Demand Analysis**

   The rationale should also include an assessment of the student market. Activities of local and regional competitors that directly or tangentially address this market niche/educational need should be analyzed. The discussion should explain how the new program would address the weakness of current competitors’ programs. It should also address the following concerns:
   - Why would students opt to come to Creighton?
   - Would this program or campus location draw students from other University programs or locations, or would it attract new learners? Competing programs?
   - What is the anticipated impact of the proposed program on the wider community, and what is the basis for this conclusion?

4. **Learning Goals/Student Outcomes**

   For all new academic programs, this section should include a statement of the broad curricular philosophy and rationale for the curricular architecture. List the learning goals/program outcomes. It should include a listing of all courses that constitute the proposed program with clear identification of all new courses and any cross listing of courses. The curricular cycle, including the timing and sequence of course offerings, the mode of delivery, and the proposed start date should be addressed.

   **Graduate Programs:** For new graduate programs, the proposal should address how the course offerings relate to the University’s mission and the graduate philosophy statement. All new program proposals should describe learning outcomes and specify methods of assessing student learning.

   All new graduate programs must meet the following curricular standards. The program:
   - Includes a minimum of 30 semester hours; a curriculum exceeding 36 semester hours requires special justification;
   - Includes a research component;
   - Includes a thesis or applied project and substantive written report.

Describe any field or internships requirements
5. **Accreditation**

This section should address all accreditation implications raised by the proposal and any steps taken to satisfy them.

6. **Assessment Plan for Student Learning**

All new academic program proposals should describe learning outcomes and specify methods of assessing student learning.

7. **External Comparisons**

This section should include a comparison of the proposed program with similar programs in other regionally accredited institutions in Nebraska and elsewhere and comparable Jesuit institutions.

8. **Resources**

This section should describe how the University has organized and planned for adequate human, financial, physical, and instructional resources to initiate and support the proposed program or site. For all resources, the proposal should clearly indicate which resources already exist, which resources must be acquired, and what strategies will be employed to acquire them. Proposals should include a discussion of the following:

**Human Resources**
- A person qualified by education and experience to administer the program
- An administrative structure through which appropriate control can be exercised
- The number and qualifications of administrative and support personnel needed to support the proposal
- Student support resources
- The number and qualifications of faculty needed to provide the instruction required by the proposal (include faculty CVs and/or proposed requirements)

**Financial Resources**
- A detailed account of the financial resources available and budgeted to cover all start-up costs as well as anticipated costs to maintain the necessary administrative, instructional, and support personnel over succeeding years
- An institutionally approved *projected budget for the first five years* of the new program including one-time start-up expenses, the anticipated sources for first-year funding, projected operating costs and income for at least five years, and a line item justification showing the derivation of each estimation of cost and revenue
- A sound business plan enumerating underlying assumptions that has been received and approved by the College’s academic governance body.

**Physical Resources**
- Adequate classroom and office space
Instructional Resources

- Admission and degree requirements for the proposal developed and approved by faculty.
- For new graduate programs, admission standards must include four of the following or their equivalents:
  1. Bachelor’s degree from a regionally accredited college or university;
  2. Demonstration of satisfactory writing ability;
  3. Demonstration of appropriate academic preparation of applicant;
  4. Specification of required grade point average for admission;
  5. Minimum TOEFL score or personal interview to assure language proficiency for international students;
  6. Other: equivalent experience, testing, etc.

- Assurance that the library core collection is adequate for faculty course preparation and student use and plans for continued growth of these holdings.

9. **Plan for Program Evaluation**

10. **Affirmative Action Considerations**

11. **Timeline**

12. **Outside Consultation** (if indicated).
New Academic Program Review and Approval Process

Phase 1: Preliminary Planning/Pre-Proposal Development

**IDEA Generation**
- Within unit or stakeholder groups
- Initial data gathering/supporting documents
- Notify Dean/Provost

**Develop Pre-Proposal**
- Address pre-proposal screening questions (Appendix A)
- Develop written pre-proposal
- Submit pre-proposal to Dean and Provost for initial approval

Phase 2: Formal Proposal Development/Internal Unit Approval

**Formal Written Proposal Development**
- After Dean and Provost have approved pre-proposal, work group assigned for full written proposal development
- Proposal guidelines are in appendix B
- Seek external community input/consultation if needed

**Internal Review and Approval**
- Full proposal reviewed by Dean(s) and appropriate VP and discussed with President; if preliminary approval is received it is sent on for internal approval
- Internal unit (School or College) reviews full proposal and makes recommendation

Phase 3: University Review and Approval

**University Academic Planning Review**
- Provost chairs academic planning review committee
- Review proposal for new academic program or degree that has received internal School or College approval
- Recommendation will be made for either approval, pending approval or reject and sent to President for final action
PURPOSE

Program review enables the University to focus attention on academic programs and to ensure that its strengths and resources are used in alignment with the mission. During the program review process, faculty members have an opportunity to reflect on their work as teachers and scholars and to engage in deliberations about strategic planning, improvement, accountability measures, and resources. Thus, program review offers academic program personnel an opportunity to review and evaluate its program(s), reflect on and refine its vision, and exchange ideas and best practices with others in order to strengthen and improve existing programs. Furthermore, ideas for new programs or innovative solutions to long-standing problems may also emerge.

Creighton requires ongoing assessment of student learning as evidence of academic excellence. Annual evaluations of student learning, in both curricular and co-curricular educational endeavors, measure six common university-level outcomes. The University Learning Outcomes address cognitive, affective, and behavioral domains of learning. Therefore, each school and college uses existing assessments of student learning as they provide evidence for the following six common university-level outcomes:

- All Creighton graduates will demonstrate
- (1) disciplinary competence and/or professional proficiency,
- (2) critical thinking skills,
- (3) Ignatian values, to include but not limited to a commitment to an exploration of faith and the promotion of justice,
- (4) the ability to communicate clearly and effectively,
- (5) deliberative reflection for personal and professional formation,
- (6) the ability to work effectively across race, ethnicity, culture, gender, religion, and sexual orientation.

The University Assessment Committee also recognizes the need to report student learning outcomes to a variety of internal and external (e.g., accreditation bodies, disciplinary groups) audiences. Creighton University embraces a culture of continuous improvement where an ongoing assessment process is not only focused on student learning and educational outcomes but also on ongoing improvement and institutional effectiveness. This requires reviews of programs using external judgments and consultation.

Creighton University’s Academic Program Review Policy arises from the University’s mission and University Learning Outcomes. Creighton exists for students and learning. Creighton University, as a Catholic, Jesuit University dedicated to excellence in undergraduate, graduate and professional programs, is committed to an ongoing process of program evaluation that includes assessment of student learning, reflection, and action that is consistent with the model of Ignatian teaching and learning. It is with a commitment to academic excellence and within an Ignatian tradition and a Jesuit, Catholic campus culture that the University fosters students’ learning. Ignatian pedagogy “aims at formation which includes but goes beyond academic mastery.” Creighton graduates will be persons for and with others.
Program review assists in identifying strong programs that need to be maintained and may help identify programs that need modification, consolidation, or elimination from the University’s academic portfolio.

POLICY

Program review is an evaluation process that allows an institution to review and ensure quality assurance for its academic programs. Creighton University is accredited by the Higher Learning Commission of the North Central Association. An assumed practice for all institutions accredited by the Higher Learning Commission is a regular program review process.

DEFINITIONS

Programs are defined as all degree programs, majors and certificate programs. Program review is an evaluative process that is done through systematic review of degree programs that provide evidence that the program is educationally sound and economically viable. External program review shall be conducted every seven (7) years unless a different schedule is required by an external accrediting body. For those programs that are in units or disciplines that undergo specialized accreditation, the on-site evaluation report, accreditation commission decisions and changes made in response to the report will serve as the external evaluation process. New programs will be scheduled for an internal review when they have at least one cohort of graduates to evaluate progress and viability.

Department chairs and/or graduate program directors and their faculty colleagues will be responsible for drawing together preliminary data for review. Review shall include a determination of the objectives of the program and its relationship to the University and College or School mission, the human and material resources required for achievement of the program goals, a determination of faculty, administration and financial support for the program, the need for graduates of the program, and the prospect for attracting adequate numbers of promising students to the program, as well as available openings for students upon their graduation. Annual evaluation data will be gathered from each program that may include enrollment, credit hour production, in-program student progress and achievements, evidence of student learning, major curricular changes, and graduate placement. Non-periodic targeted program review may occur in response to a request from either the program, Dean, or Provost or (his or her designee). Final determination of the establishment and retention of each program will be made based on recommendations from the review, recommendations from an existing governing group (Graduate Board for the graduate programs), the University Program Review Committee and on the authority of the President in consultation with the Dean(s), Provost.

Flowchart document provides an overview of the review process.

Systematic program review provides a vehicle for ensuring the following:

- Evidence of educational quality and consistency with national trends
- Documentation of student performance and achievement of stated program outcomes within the context of the University mission
- Evaluation of resources including student support, faculty, space
Policies and Procedures

SECTION: Academic Concerns

CHAPTER: General

POLICY: Academic Program Review Policy

• Improvement of educational quality and strategies for improvement
• An evaluative process which identifies strengths and weaknesses with a forward looking projection
• Program review results should result in action

PROCEDURE

Academic Program Review consists of five phases: (1) Planning and Preparation, (2) Self-study, (3) External Review, (4) Summary, (5) Recommendation and Action. (refer to flow charts for guidance) The Office of Academic Excellence and Assessment serves as the coordinating unit for this program review function.

Phase 1: Planning and Preparation

Notification Academic Unit
One year in advance of the review, the Associate Vice President for Academic Excellence and Evaluation will, after appropriate consultation with the lead/chair of the academic program/unit and the school/college dean(s), that a review has been scheduled.

Appointment of the Self-Study Committee
Eight months prior to the self-study submission date, the head of the academic program/unit should establish a self-study committee (size of this group will vary across programs).

Unit Planning Meetings with University Program Review Staff
At least six months prior to the self-study submission deadline, the academic program/unit should schedule a meeting with the Office for Academic Excellence and Assessment (AEA). The meeting will include representatives of the Office for AEA, representatives of the program, the supervising school/college dean, and other deans as applicable. The purpose of the meeting is to address the coordination and scheduling of the work associated with the program review.

Nomination/Selection of Reviewers
The head of the academic program/unit, in consultation with appropriate departmental committee and faculty and with supervising dean’s approval, should submit a list of names and qualifications of six potential reviewers (two internal reviewers and four external reviewers). Reviewers will be expected to conduct the review based on the self-study document and materials, and if necessary, a telephone and video conference with program representatives. There will not be an on-campus visit scheduled. At least two of the prospective reviewers should be from the relevant disciplinary area. The review team will include two external and one internal reviewer.
In consultation with the school/college dean and the appropriate vice-president or provost, three reviewers will be selected and notification made by the Office for Academic Excellence and Assessment.

**Phase 2: The Self Study Report Phase**

**Document Preparation**
The Self-Study Report is an interpretive document that uses data to assess current program status and future direction. The university will provide to the unit a standard self-study document template and standard data set. Data should be analyzed and discussed in relation to the academic program/unit’s mission and goals.

**Document Distribution**
The school/college dean will review the Self-Study Document and executive summary before the materials are forwarded to the Office for Academic Excellence and Assessment who will distribute the document to site visitors and appropriate university administrators.

**Phase 3: Program Review Phase**

**External Review**
The review team will analyze the program self-study document, and as necessary, collect additional relevant information, conduct telephone or video conferences with appropriate faculty, administrators, students, and community groups.

**Report**
The reviewers (external and internal) will prepare a report identifying program strengths, concerns, and recommendations. A recommendation will be made with a supporting rationale as to whether the program should be maintained, strengthened, monitored or discontinued. If the recommendation is to maintain, strengthen, or monitor the program, the review team also will be asked to provide an assessment of the future direction and strategic initiatives of the unit as they relate to the unit’s mission and vision for its program. The reviewers will submit their report within three weeks of completing the interviews to the Office of Academic Excellence and Assessment for appropriate distribution.

**Phase 4: The Summary Phase**

**Academic Program/Unit’s Response Report to the Reviewer’s Report**
Once the reviewer’s report is received, the head of the academic program/unit, the involved deans, and the Provost (or his or her designee) will review the report. The head of the academic program/unit should review and discuss the report with the faculty and prepare an Academic Program/Unit Response Report that addresses the reviewer’s concerns and recommendations. The Academic Program/Unit Response Report will be shared with the involved dean(s) and the Provost (or his or her designee).
Wrap-Up Phase
The unit head and the supervising dean summarize the final assessment in a joint wrap-up letter. This phase may also include a meeting of the academic program/unit, the Associate Vice President for Academic Excellence and Assessment, the supervising dean, other deans, and the provost or his or her designee, if there are concerns or if further clarification is deemed necessary before the final wrap-up letter is prepared. The supervising dean may invite others to participate in this meeting. The wrap-up letter, self-study document, and review report will be forwarded to the Office for Academic Excellence and Assessment for distribution to the Program Review Subcommittee of the University Assessment Committee.

Phase 5: The Recommendation and Action Phase

Program Review Subcommittee Assessment
The Program Review Subcommittee of the University Assessment Committee will review the Self-study report, Reviewer Report, Academic Program Response, and the Wrap-up letter to check for consistency of process. The Subcommittee will then re-affirm the recommendation being made or propose an alternative.

Permanent Record of the Program Review
The Self-Study Document, the Review Report, Academic Program/Unit Response Report, the Wrap-up letter and the Program Review Subcommittee Assessment will be considered as the permanent record of the review. These summary documents will be collated by the Office for Academic Excellence and Assessment and forwarded to the Provost. The Provost (or his or her designee) will provide a summary memo and distribute final materials to the Academic Unit/Dean(s) and the President.

The Academic Program/Unit head and supervising dean will establish a plan of action to strengthen, improve or discontinue the academic program. The plan of action will be submitted to the Provost within the timeframe specified in the summary memo. If the recommendation is for discontinuation, procedures are followed according to the Faculty Handbook.

SCOPE

1. Key Features of Program Review: Key features of the program review include:
   - The review is evaluative in nature, not merely descriptive.
   - The review of programs is forward-looking.
   - The review must include academic strengths and weaknesses.
   - The review is objective and is based on the self-study document (specialized accreditation process may serve as program review with additional focused questions).
   - The review is an independent process.
   - The review findings should result in action.
II. Key Questions in Program Review: The program review will focus on the following questions:
- 1. Is the program advancing the state of the discipline or profession?
- 2. Is the teaching and training of students effective?
- 3. Does the program meet the institution’s goals?
- 4. Does the program respond to the profession/discipline’s needs?
- 5. How is the program assessed by experts in the field?

III. Key Elements for Successful Program Review: A successful program review is based on key elements including:
- 1. Clear, consistent guidelines
- 2. Administrative support (e.g., accurate institutional data; resources for external reviewers)
- 3. Departmental self-study
- 4. Student participation
- 5. Review committee
- 6. Reviewers (internal and external)
- 7. Final report and recommendations/actions
- 8. Link program review process to outcomes-based assessment

IV. The program review consists of three goals:

**Goal I: Recruitment and admission of a qualified and diverse applicant pool:** Evaluation of success of recruitment activities should include the trends in:
- Average admission profiles/entrance exams (e.g., GRE, ACT/SAT, GMAT, LSAT, MCAT, etc.) are within acceptable limits.
- Admission records demonstrate adequate selectivity.
- Assess the trends in credit hours generated over time (stable, increasing or decreasing).
- Diversity of student by gender and ethnicity
- Number of students admitted and credit hours generated in each graduate program is adequate to assure quality of education and opportunity for interaction.

**Goal II: Assure Quality of Programs:** Evaluation of success in achieving quality of programs includes trends in:
- Student quality:
  - All criteria considered in evaluating Goal I, plus, for doctoral programs, delivery of student papers at prestigious meetings.
  - Quality of comprehensive examinations or the program equivalent (e.g., capstones, theses, dissertations, portfolios upon graduation).
### Policies and Procedures

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- **Quality of Instruction/Faculty:**
  - Examination of Curriculum Vitae of existing faculty during cyclical review;
  - Examination of curriculum vitae of adjunct faculty hired to teach courses;
  - On-going evaluation of student satisfaction and student learning outcomes;
  - Evidence of rigor in expectations;
  - Scholarly productivity of faculty;
  - Extramural funding obtained in comparison to benchmark institutions;
  - Satisfaction surveys of graduates and alumni at specified intervals (e.g., every 3 or 5 years post graduation)

- **Quality of resources available:**
  - Adequacy of laboratory and classroom space for program;
  - Adequacy of technology to support purposes of program;
  - Adequacy of library resources for supporting the program and the scholarly work of the faculty teaching in the program;
  - Revenue and expenditure history since last program review cycle

- **Quality of outcomes**
  - Assessment of formative and summative outcomes
    - Programmatic goals and objectives, stated as learning outcomes, that are operational and specific;
    - Procedures to regularly evaluate the extent to which the goals and objectives are being achieved
    - Evidence that results of the assessment are used to improve the program
  - Five-year evaluation
    - Employment type and evaluation of appropriateness of education received in obtaining and performing well in this employment
    - Number of students obtaining a master’s who are accepted into a doctoral program
    - Quality of doctoral/post-doctoral positions obtained
    - Alumni satisfaction

**Goal III: Promote Scholarship among Faculty:** Evaluation of success in promoting scholarship among faculty can include trends in:

- Self-report of number and quality of publications resulting from seed grants;
- Self-report of activities and publications (number and quality) resulting from summer faculty fellowships;
- Self-report of number of publications by faculty per calendar year;
- Report of number of books published;
- External reviews/awards of any faculty publications;
- Evidence of dissemination of the results of faculty publications;
- Evidence of increased grant funding;
**Policies and Procedures**

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- Presentations at significant meetings of disciplinary/professional peers;
- Evidence of impact of scholarly activity on the discipline/profession;
- Development of collaborations in scholarly endeavors.

**ADMINISTRATION AND INTERPRETATIONS**

**Glossary:**

**Academic Unit:** An academic unit is a general term and refers to degrees, graduate level certificate programs, and majors within a college, school, or program. Each academic unit will have at least one assessment system.

**Assessment:** Assessment includes the collection and analysis of data with the intent of improving the delivery of educational programs, particularly in the areas of student learning outcomes. Assessment is not collecting and analyzing data to explicate only strengths of academic programs. Assessment should reveal areas targeted for improvement.

**Assessment for Accountability:** Assessment of some unit (e.g., department, program, university) to satisfy external stakeholders. Results are often compiled and compared across units. It is summative in nature to meet pre-identified criteria or thresholds.

**Assessment for Improvement:** Assessment that feeds directly, and sometimes immediately to a course, program or institution to improve student learning outcomes is assessment for improvement. Such data can be formative or summative.

**Assessment of Individuals:** Assessment of individual students and their learning is the level of analysis. The data can be quantitative or qualitative, formative or summative, standards-based or value added, and used for improvement. Such individual data would need to be aggregated for accountability purposes.

**Assessment of Institutions:** The level of analysis is the institution. Such data can be quantitative or qualitative, formative or summative, standards-based or value added, and used for improvement or for accountability. Ideally, institution-wide goals or outcomes serve as the basis for assessment.

**Assessment Measures:** Assessment measures are the tools that will be used to evaluate student learning. The measure addresses one or more of the performance indicators for a given learning outcomes, such as a project, writing sample, research report or clinical assessment form.

**Assessment System/Plan:** An assessment system is a detailed description of the process used to implement a cycle of assessment supporting continuous program or curricular improvement. This system consists of specified student learning outcomes, measurement tools/processes for the achievement of each learning outcome, and a structure for use of assessment results for curricular improvement.
Co-Curricular: Co-curricular programs are planned activities and formal programs that add to and support the student learning offered by academic support units. Examples include, but are not limited to, Ratio Studiorum or similar programs, Migrant Journey and other Service Learning Programs, International Programs, Campus Ministry, Creighton Center for Service and Justice, Cortina Community and Freshman Leadership Program. Three styles of co-curricular experiences can occur:

- When embedded into the course, learning becomes part of the course or program requirements and is assessed as such.
- When the learning experience is associated with but not directed by the course’s requirements, assessment will be most appropriate when the outcomes are created collaboratively to support both course and programmatic expectations.
- Learning initiatives coordinated outside of the classroom and not linked to an academic component should reflect outcomes that are aligned with overall University level learning outcomes and direct measures of assessment should be used.

Course: A term used to describe a structured and organized learning activity for academic credit or continuing education units.

Direct Measures: Data collected on students’ actual performance of their learning to produce work so that faculty can assess how well students are meeting the intended learning outcomes. Examples include papers, exams, clinical performance, art work, recital, etc.

Educational Objectives: Educational objectives are expected learning outcomes for students that relate to knowledge, skills, abilities, capacities, attitudes or dispositions that result upon completion of a class session, course, program, etc. Objectives are often used synonymous with educational outcomes, though objectives are usually more detailed, behavioral in nature, and stated in precise operational terms (see Learning Outcomes).

Embedded Assessment: Embedded assessments gather information about student learning that is built into the teaching learning process. Embedded assessment are often course assignments, activities, or exercises that are completed as part of a class, but that are used to provide assessment data about a particular learning outcome. The course instructor and/or other evaluators evaluate the student work, often using a grading rubric.

Evaluation: The use of assessment findings (i.e., data/evidence) that is used to judge program effectiveness and used as a basis for making decisions about program changes or improvement.

External Assessment: Use of criteria (rubric) or an instrument developed by an individual or organization external to the one being assessed. External assessments are usually summative, quantitative, and often high-stakes. Examples include the Graduate Record Examination (GRE) or professional certification exams.
Formative Assessment: Data that are collected and analyzed for purposes of change or improvement. Examples include reading first drafts of papers and assessing which students need assistance to write more succinctly and informatively.

Goals: Goals are the general aims or purposes of a program and its curriculum. Effective goals are stated as meaningful, broad, achievable and measureable. Goals provide a framework for determining the more specific educational objectives of a program, and should be consistent with the program and institutional mission.

High Stakes Assessment: High stakes assessment is used to make a decision about progression. High stakes assessments can be externally developed to ensure that the assessment is valid and reliable. High stakes assessments include standards that must be met in order to progress in a program (e.g., GRE requirements for admission, successful completion of a clinical experience to proceed to the next clinical experience).

Indirect Measures: Data captured from students’ perceptions of their learning and the educational environment that support that learning. Such data may or may not be completely accurate due to it being a secondary level of evidence. Examples include student satisfaction surveys, student self-assessment tools.

Learning Outcomes: Learning outcomes are operational statements that describe behaviors related to the achievement of desired knowledge, skills, abilities, capacities, attitudes or dispositions. Outcomes are often synonymously referred to as objectives, though outcomes are usually more generally stated.

Public: In phrases such as “makes available to the public” or “states publically” refer to people in general, including current and potential students.

Qualitative Assessment: Data that are collected and does not lend themselves to quantitative methods of analysis, but rather to interpretive criteria. Examples include transcriptions of a focus group or comments from employers about the performance of graduates.

Quantitative Assessment: Data that are collected and analyzed using quantitative methods or statistics.

Quality Assurance: Quality assurance is the hallmark of higher education in that it entails a systematic review of academic programs’ evidence for purposes of educational and economic viability.

Standards: Standards set a level of accomplishment all students are expected to meet or exceed. Standards do not necessarily imply high quality of learning; rather, they may be minimal criteria for acceptable performance.
**Policies and Procedures**

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**Summative Assessment:** Data that are collected and analyzed to provide evidence upon conclusion of an activity or program, usually for decision making purposes to improve or meet accountability demands.

**Triangulation:** Triangulating data is the collection of multiple data points in order to determine if the results show a consistent outcome.

**Value Added:** Value added is the increase in learning that occurs during a course or program. It can either focus on individual students learning or a cohort of students. Assessing value added components requires a baseline measurement for comparison purposes.

**AMENDMENTS OR TERMINATION OF POLICY**

The University reserves the right to modify, amend or terminate this policy at any time.
Program Review Process

Phase 1: Planning and Preparation

Academic Excellence and Assessment /Notification
- Office of AEA will have master schedule and notify Academic unit and Dean of pending review

Academic Unit and Dean(s)
- Establish Self-Study Committee to develop the document (size will depend on program)

Academic Unit, Dean(s), and Self-Study Committee
- 6 mos prior to visit; AEA will meet with academic unit reps, supervising dean(s) to discuss coordination of process and visit
- Identify information needed for self-study
- Generate list of potential reviewers (6; No more than 2 internal)

Phase 2: Self-Study Report Phase

Academic Unit, Dean(s), and Self-Study Committee
- Prepare Self-Study document
- AEA/Office of Institutional Research in conjunction with School/College will provide standard template and data set
- Self-Study document submitted to AEA

Academic Excellence and Assessment
- Review Self-Study document for completeness
- Distribute Self-Study document to reviewers and University administration
- Orient the reviewers to the review process

Phase 3: Program Review

Internal/External Reviewers
- Conduct virtual review (2 external/1 internal)
- Generate Summary Report and make an overall recommendation for the program
  - Maintain
  - Strengthen
  - Monitor
  - Discontinue
- Report/Recommendation distributed by AEA to Academic Unit, Dean(s), and Provost
Program Review Process

Phase 4: Summary Phase

**Academic Unit and Dean(s) Response Report**
- Provide written response to Self-Study Report/recommendation
- Response distributed to AEA to Provost
- Final joint wrap up letter should be done by acad unit, Dean and Provost

**Academic Excellence and Assessment**
- Distribute the Self-Study Report, recommendation, written response and wrap-up letter to UAC Subcommittee on Program Review

Phase 5: Recommendation and Action Phase

**UAC Subcommittee on Program Review**
- Review the Self-Study Report, reviewers’ report and academic unit response and wrap-up letter to re-affirm the recommendations made or propose alternatives.

**Academic Excellence and Assessment /Permanent record**
- Summary document file will be collated by AEA and distributed to the Provost
- AEA will maintain permanent record of program review documents

**Provost**
- Provide a summary memo (includes the recommendation)
- Distribute final materials to the academic unit, deans and the President
- A plan of action will be submitted to the Provost by the academic unit/deans within a timeframe specified in the Provost’s summary memo
- If the recommendation is for discontinuation, procedures are followed according to the Faculty Handbook
Faculty with non-tenure track appointments are subject to the same review as those in tenure tracks.
**Policies and Procedures**

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**PURPOSE**

The purpose of this policy is to establish procedures to thoroughly, timely, objectively, and fairly evaluate, investigate, and respond to allegations of research misconduct to protect the health and safety of the public and promote the integrity of research, research training, or activities related to that research or research training conducted at Creighton University and to protect Federal funds and equipment, as appropriate.

**POLICY**

Creighton University fosters a research environment that promotes the responsible conduct of research, research training, and activities related to that research or research training. Creighton University shall promptly respond to all allegations or evidence of possible research misconduct according to this policy and shall report, as required by law, any investigation and finding of research misconduct by any faculty, staff, student, or agent of Creighton University.

**SCOPE**

This policy applies to faculty, staff, students, and agents of Creighton University engaged in research, research training, or activities related to research or research training for which Federal funds, including, but not limited to, US Public Health Service (“PHS”) funds, are requested or provided (“Federal funds”). This policy applies to allegations of research misconduct in research, research training, or activities related thereto, and research misconduct involving applications or proposals for Federal funding of research, research training, or activities related thereto. It also applies to any research proposed, performed, reviewed, or reported, or any research record generated from that research, regardless of whether an application or proposal for Federal funding resulted in a grant, contract, cooperative agreement, or other form of support.

**DEFINITIONS**

- **Complainant** means any person who in good faith makes an allegation of research misconduct.
- **Preponderance of the Evidence** means proof by information that, compared with opposing information, leads to the conclusion that the fact at issue is more probably true than not.
- **Research** means a systematic experiment, study, evaluation, demonstration, or survey designed to develop or contribute to general knowledge (basic research) or specific knowledge (applied research), including, but not limited to, research relating broadly to public health by establishing, discovering, developing, elucidating, or confirming information about, or the underlying mechanism relating to, biological causes, functions or effects, diseases, treatments, or related matters to be studied, and research in engineering, mathematics, economics, education, linguistics, psychology, physical sciences, social sciences, and statistics.
Research Record means the record of data or results that embody the facts resulting from scientific inquiry, including, but not limited to, research proposals, laboratory records (both physical and electronic), progress reports, abstracts, theses, oral presentations, internal reports, journal articles, and any documents and materials provided by the Respondent during the course of the research misconduct proceeding.

Research Misconduct means fabrication, falsification, or plagiarism (as those terms are defined below) in proposing, performing, or reviewing research or in reporting research results. It does not include honest error or differences of opinion.

Fabrication is making up data or results and recording or reporting them.

Falsification is manipulating research materials, equipment, or processes, or changing or omitting data or results such that the research is not accurately represented in the research record.

Plagiarism is the appropriation of another person's ideas, processes, results, or words without giving appropriate credit.

Respondent means the person against whom an allegation of research misconduct is made, and is the subject of a research misconduct proceeding.

PROCEDURE

11. General Institutional Responsibilities
   a. Phases of a Research Misconduct Proceeding
      Creighton University shall take the following steps in response to an allegation of research misconduct:
         i. Allegation of Research Misconduct. A report, either written or oral, of possible research misconduct is filed.
         ii. Institutional Inquiry. A preliminary information-gathering and fact finding process to assess whether the allegation has substance to warrant an investigation is begun.
         iii. Notices. Notices are sent to the Respondent, Complainants, the Dean, the Provost, the Research Compliance Officer, the Office of General Counsel, and to any applicable Federal agency or its designee (e.g., the Office of Research Integrity) of any decision to initiate an investigation of research misconduct.
         iv. Institutional Investigation. The institution begins formal development of a factual record, and examines that record, leading to either a decision not to make a finding of research misconduct or to a recommendation for a finding of research misconduct, which may include a recommendation for corrective action or other appropriate actions.
v. **Federal Agency Notice.** Notice of institutional investigation findings and actions related to the research misconduct proceeding is sent to any applicable Federal agency that funds or has oversight of the research activity involved in the research misconduct proceedings or its designee. The Research Compliance Officer, in consultation with the Office of General Counsel, shall provide all required notices to Federal agencies under this policy.

b. **Confidentiality**

   i. **Identity of Participants in Research Misconduct Proceedings.** Disclosure of the identity of Respondents, Complainants, and witnesses involved in research misconduct proceedings is limited to those who need to know, to the extent possible, consistent with a thorough, competent, objective, and fair research misconduct proceeding, and as allowed or required by law.

   ii. **Records and Evidence.** Except as otherwise required by law, confidentiality of all records and evidence from which research subjects might be identified shall be maintained. Disclosure of such information is limited to those who have a need to know to carry out a research misconduct proceeding.

c. **Safeguards**

   The rights, privacy, positions and reputations of all parties involved in the research misconduct proceedings shall be protected. No one shall retaliate against any Complainant, witness, or committee member who, in good faith, participates in a research misconduct proceeding.

   i. All reasonable and practical efforts shall be taken to restore the position and reputation of Respondents in cases in which there is no finding of research misconduct.

   ii. All reasonable and practical efforts shall be taken to restore the position and reputation of any Complainant, witness, or committee member and to counter potential or actual retaliation against these individuals.

   iii. Disciplinary action will be taken, in accordance with University policy, against anyone who fails to act in good faith in either bringing an allegation of research misconduct, cooperating during the research misconduct proceedings (i.e., providing evidence), or serving as a member of either the Ad Hoc Inquiry or Ad Hoc Investigative Committee. An allegation or cooperation with a research misconduct proceeding is not in good faith if made with knowing or reckless disregard for information that would negate the allegation or testimony. A committee member does not act in good faith if his/her acts or omissions on the committee are dishonest or influenced by personal, professional, or financial conflicts of interest with those involved in the research misconduct proceeding.

d. **Mandatory Notice to Federal Agency during Initial Report/Inquiry or Investigation.**

   At any time during a research misconduct proceeding, Creighton University (Research Compliance Officer) shall immediately notify the relevant Federal agency or its designee if it has reason to believe that:

   i. Research activities should be suspended;
### Research Misconduct In Federally Funded Research

| ii. | The health or safety of the public is at risk, including an immediate need to protect human or animal subjects; |
| iii. | Federal agency resources or interests are threatened; |
| iv. | Federal action is required to protect the interests of those involved in the research misconduct proceeding; |
| v. | The research community or public should be informed; |
| vi. | There is reasonable indication of possible violations of civil or criminal law; or |
| vii. | The research misconduct proceedings may be made public prematurely so that the appropriate Federal agency can take appropriate steps to safeguard evidence and protect the rights of those involved. In such an instance, the Dean(s) of the School/College conducting the research misconduct proceeding shall notify the Research Compliance Officer, who shall notify the appropriate Federal agencies. |

### 12. Allegation of Research Misconduct Stage

#### a. Receipt of an Allegation of Research Misconduct

A good faith report of possible research misconduct may be made, either verbally or in writing, to any University official, including, but not limited to, the reporting individual’s supervisor, administrator, the Provost or Dean, the Research Compliance Officer (402-280-2360), or the Research Compliance Hotline (402-280-3200). A report of possible research misconduct is not in good faith if it is made with knowing or reckless disregard for information that would negate the allegation. The report of possible research misconduct shall be documented (if not already documented by the Complainant) and immediately sent to the Dean(s) of the School/College under which the research is conducted and the Research Compliance Officer. If there is more than one school/college involved in the allegation of research misconduct, the Deans of those schools/colleges shall be jointly responsible for determining whether an inquiry is warranted, setting the inquiry date, and appointing members to the Ad Hoc Inquiry Committee, and where necessary, the Ad Hoc Investigative Committee.

#### b. Review of Allegation by Dean(s)

The Dean(s) shall review the allegation of research misconduct to determine whether the research, research training, or activities related to research or research training involve Federal funds, and whether an inquiry is warranted. An inquiry is warranted if the allegation falls within the definition of research misconduct under the “Definitions” section of this policy and it is sufficiently credible and specific that potential evidence of research misconduct may be identified. If the research, research training, or activities related to research or research training does/do not involve Federal funds or the allegation does not fall within the definition of research misconduct hereunder, the Dean(s) will refer to the policy on Misconduct in Non-Federally Funded Scholarly and Scientific Research.
In the event the allegation of research misconduct involves a Dean or the Dean has a real or apparent conflict of interest in the matter, the determination of whether an inquiry is warranted and the completion of all other responsibilities set forth for the Dean herein will be completed by the Provost or his/her designee.

c. Setting the Date of Institutional Inquiry and Appointment of Ad Hoc Committees
If the Dean(s) determines that an inquiry is warranted pursuant to paragraph b above, a date(s) for the institutional inquiry shall be scheduled. The Dean(s) shall then appoint an Ad Hoc Inquiry Committee to conduct an initial review of the evidence to determine whether to conduct an investigation. If necessary, the Dean(s) shall also appoint an Ad Hoc Investigative Committee. The Dean(s) shall make every effort to appoint persons with appropriate knowledge and expertise to the Ad Hoc Committees and shall ensure that anyone appointed to either Ad Hoc Committee does not have unresolved personal, professional, or financial conflicts of interest with the Complainant(s), Respondent(s), or witnesses. The Ad Hoc Committees shall be composed of such persons whom the Dean(s) may choose to designate to serve, provided, however, that at least two (2) members shall be from outside the affected department/division. It is desirable that an appropriate Associate/Assistant Dean and two tenured faculty members of the school/college involved be appointed to the Ad Hoc Committee, but this is not a formal requirement. Members of the Ad Hoc Investigative Committee may include some or all of the members from the Ad Hoc Inquiry Committee, as well as other members as may be appointed by the Dean(s). Individuals from the department of the Complainant(s) or Respondent(s) should not participate in either Ad Hoc Committee. The Dean(s) shall designate one of the Ad Hoc Committee members to act as Chair for each Ad Hoc Committee. The Ad Hoc Committees may rely upon consultants with expertise or knowledge in the area of research under inquiry and/or investigation.

d. Notice to Respondent(s) of Allegation
The Dean(s) shall notify the presumed Respondent(s), in writing, of the allegation of research misconduct prior to the start of the institutional inquiry. A copy of the notice shall be sent to the Respondent’s departmental chairperson, administrator, or supervisor, the Provost, the Research Compliance Officer, and the Office of General Counsel.

e. Custody of Research Records
On or before the date on which the Respondent(s) is notified, the Dean(s) shall take all reasonable and practical steps to obtain custody of all known research records and evidence needed to conduct the research misconduct proceeding, inventory the records and evidence, and hold them in a secure manner to be available for the research misconduct proceedings. Where the research records or evidence encompass scientific instruments shared by a number of users, custody may be limited to copies of the data or evidence on such instruments, so long as those copies are substantially equivalent to the evidentiary value of the instruments.
### f. Ensuring Cooperation During the Research Misconduct Proceeding

Faculty, staff, students, and agents, including Complainant(s), Respondent(s), and witnesses, shall cooperate in the research misconduct proceedings, including, but not limited to, being present as requested during the research misconduct proceeding and providing relevant and truthful information and research records and evidence.

### 13. Institutional Inquiry Stage

#### Review by Ad Hoc Inquiry Committee

The Ad Hoc Inquiry Committee shall conduct an initial review of the evidence to determine whether to conduct an investigation. A full review of the evidence related to the allegation is not required at this stage. The inquiry must be completed within 60 calendar days (including the opportunity for Respondent’s review and comment, section c.ii. below) of its initiation, unless circumstances warrant a longer period, in which case the inquiry record must include documentation of the reasons for exceeding the 60-day period.

##### i. Custody of Research Records

The Dean(s) shall turn over custody of all research records and evidence collected during the allegation stage to the Ad Hoc Inquiry Committee. The Ad Hoc Inquiry Committee shall take custody, inventory, and secure those items and any additional research records or evidence discovered during the course of the inquiry; in cases in which the research records or evidence encompass scientific instruments shared by a number of users, custody may be limited to copies of the data or evidence on such instruments, so long as those copies are substantially equivalent to the evidentiary value of the instruments.

##### ii. Respondent(s)’ Access to Research Records

Prior to and during the inquiry stage, the Respondent(s) shall have the right to receive copies of or reasonable supervised access to the research records.

### 14. Criteria Warranting an Investigation

An investigation is warranted if there is:

##### i. A reasonable basis for concluding that the allegation falls within the definition of research misconduct under this policy and involves research, research training, or activities related to that research or research training, and

##### ii. Preliminary information gathering and fact finding from the inquiry indicates that the allegation may have substance.

### 15. Inquiry Report

#### i. Draft Report

The Ad Hoc Inquiry Committee shall prepare a written draft report that shall include the following information:

1. The name and position of the Respondent(s);
2. A description of the allegations of research misconduct;
3. A description of the allegations of research misconduct;
4. The basis for recommending that the alleged actions warrant an investigation.

ii. Opportunity to Comment
The Ad Hoc Inquiry Committee shall provide a copy of the written inquiry report to the Respondent(s) for review and comment. The Respondent shall have ten (10) days from receipt of the report to submit any written comments.

iii. Final Report
The final report shall include any written comments received from the Respondent(s) within the time period set forth in paragraph b above.

16. Notice of Final Inquiry Results
i. Notice to Respondent(s)
The Ad Hoc Inquiry Committee shall give written notice to the Respondent(s) of whether the inquiry found that an investigation is warranted. The notice shall include a copy of the final inquiry report along with a copy of this policy. The notice shall also include either a copy of or reference to 42 CFR Part 93.

ii. Notice to Complainant(s)
The Ad Hoc Inquiry Committee may notify the Complainant(s) of whether the inquiry found that an investigation is warranted. The notice may include relevant portions of the inquiry report for comment by the Complainant(s).

iii. Notice to Institutional Officials
The Ad Hoc Inquiry Committee shall promptly provide a copy of the final inquiry report to the Dean(s) who appointed the Ad Hoc Inquiry Committee, the Provost, the Research Compliance Officer, and the Office of General Counsel. Names of Complainants, witnesses, and research subjects shall be redacted to maintain confidentiality.

17. Finding That Investigation is Warranted
The Research Compliance Officer shall notify any applicable Federal agency funding the affected research or its designee of the decision to begin an investigation, on or before the date the investigation begins, which shall be no more than thirty (30) days from the date of the final inquiry report of the Ad Hoc Inquiry Committee finding that an investigation is warranted. The notice shall include a written finding by the Ad Hoc Inquiry Committee Chair and a copy of the final inquiry report, including any comments by the Respondent(s) or Complainant(s). Upon request, Creighton shall provide the Federal agency or its designee with a copy of this policy, the research records and evidence reviewed, transcripts or recordings of any interviews, copies of all relevant documents, and the charges the investigation will consider. The Federal agency or its designee shall be notified of any special circumstances that may exist.
18. Finding That an Investigation is Not Warranted
The Ad Hoc Committee shall sufficiently document the decision not to investigate the allegation of research misconduct and shall submit all records of the allegation and inquiry stages to the Dean and the Research Compliance Officer to maintain in accordance with section 7 below.

19. Institutional Investigation Stage
   a. Institutional Investigation Stage
      If not already appointed, the Dean(s) shall, no later than five (5) days after the issuance of the final inquiry report, appoint an Ad Hoc Investigative Committee. Such appointment shall be in accordance with the appointment requirements set forth in paragraph 2.c. above.
   b. Scheduling the Investigation and Required Notices
      i. Time Period for Initiating and Completing the Investigation. The Ad Hoc Investigative Committee shall begin the investigation no later than thirty (30) days after the final inquiry report of the Ad Hoc Inquiry Committee finding that an investigation is warranted. The Ad Hoc Investigative Committee shall complete all aspects of the investigation within 120 days from the date of initiating the investigation, which includes conducting the investigation, preparing the report of findings, providing the draft report to and obtaining comments from the Respondent(s), and sending the final report to any applicable Federal agency. If Federal funding is involved and the Ad Hoc Investigative Committee determines that the investigation and related activities will not be complete within the 120 day period, it shall notify the Research Compliance Officer (no later than 85 days after the start of the investigation), who shall immediately submit a written request to the applicable Federal agency requesting an extension. The Research Compliance Officer shall notify the Ad Hoc Investigative Committee of the Federal agency’s response.
      ii. Time Period for Initiating and Completing the Investigation. The Ad Hoc Investigative Committee shall begin the investigation no later than thirty (30) days after the final inquiry report of the Ad Hoc Inquiry Committee finding that an investigation is warranted. The Ad Hoc Investigative Committee shall complete all aspects of the investigation within 120 days from the date of initiating the investigation, which includes conducting the investigation, preparing the report of findings, providing the draft report to and obtaining comments from the Respondent(s), and sending the final report to any applicable Federal agency. If Federal funding is involved and the Ad Hoc Investigative Committee determines that the investigation and related activities will not be complete within the 120 day period, it shall notify the Research Compliance Officer (no later than 85 days after the start of the investigation), who shall immediately submit a written request to the applicable Federal agency requesting an extension. The Research Compliance Officer shall notify the Ad Hoc Investigative Committee of the Federal agency’s response.
Research Misconduct in Federally Funded Research

**c. Investigation by the Ad Hoc Investigative Committee**

The Ad Hoc Investigative Committee shall fairly and impartially conduct a thorough review of all research records and evidence and diligently pursue all relevant significant issues and leads (including evidence of additional instances of possible research misconduct) in determining whether there was research misconduct.

i. **Custody of Research Records.** The Ad Hoc Inquiry Committee shall turn over custody of all research records and evidence in its possession to the Ad Hoc Investigative Committee prior to the start of the investigation.

The Ad Hoc Investigative Committee shall take custody of, inventory, and secure those items and during the course of the investigation any additional research records or evidence that become known or relevant to the investigation, except that where the research records or evidence encompass scientific instruments shared by a number of users, custody may be limited to copies of the data or evidence on such instruments, so long as those copies are substantially equivalent to the evidentiary value of the instruments.

ii. **Respondent’s Right to Legal Counsel and to Access Research Records**

1. Respondent(s) shall have the right to have their legal counsel present during their testimony before the Ad Hoc Investigative Committee. Legal counsel shall not have the right to cross-examine witnesses nor to address the Ad Hoc Committee.

2. Prior to and during the investigation stage, the Respondent(s) has the right to receive copies of or be given reasonable supervised access to the research records.

iii. **Interviews.** The Ad Hoc Investigative Committee shall interview each Respondent, Complainant, and any other available persons who have been identified as having relevant information, including persons identified by the Respondent(s). Interviews shall be recorded or transcribed, with a copy provided to the interviewee for correction. The recording or transcript shall be included in the record of the investigation and be considered a part of the investigative record.

iv. **Contact with Dean(s) and Research Compliance Officer.** The Ad Hoc Investigative Committee shall keep the Dean(s) of the affected School/College and the Research Compliance Officer apprised of any developments during the course of the investigation that disclose facts that may affect current or potential agency funding for the Respondent(s), or that the funding agency needs to know to ensure appropriate use of Federal funds and to otherwise protect the public interest. The Research Compliance Officer shall then notify the funding agency or its designee, as may be required by law.
d. Criteria for Finding of Research Misconduct

To support a finding of research misconduct, the Ad Hoc Investigative Committee must find by a preponderance of the evidence that:

- There was a significant departure from accepted practices of the relevant research community; and
- The misconduct was committed intentionally, knowingly, or recklessly; and
- The allegation was proven by a preponderance of the evidence.

i. Destruction, Absence of, or Respondent(s)’ Failure to Provide Research Records. The destruction, absence of, or Respondent’s failure to provide research records adequately documenting the questioned research is evidence of research misconduct where it is established by a preponderance of the evidence that the Respondent(s) intentionally, knowingly, or recklessly had research records and destroyed them, had the opportunity to maintain the records but did not do so, or maintained the records and failed to produce them in a timely manner, and that the Respondent(s)’ conduct constitutes a significant departure from accepted practices of the relevant research community.

ii. Respondent(s)’ Burden of Proof. Respondent(s) have the burden of proving, by a preponderance of the evidence any and all affirmative defenses or mitigating factors. The Ad Hoc Investigative Committee shall give due consideration to admissible, credible evidence of honest error or difference of opinion presented by the Respondent(s).

e. Investigation Report

i. Draft Report. The Ad Hoc Investigative Committee shall prepare a written draft investigation report that shall include the following information:

- **Allegations.** A description of the nature of the allegations of research misconduct.
- **Funding.** A description of the source of funding, including, for example, any grant numbers, grant applications, contracts, and publications listing funding support.
- **Institutional Charge.** A description of the specific allegations of research misconduct considered during the investigation.
- **Policies and Procedures.** If not already included in the inquiry report, include a copy of this policy.
- **Research Records and Evidence.** Identity and summary of research records and evidence reviewed, as well as records and evidence taken into custody but not reviewed.
- **Statement of Findings.** A finding of whether research misconduct did or did not occur for each separate allegation of research misconduct considered during the investigation. For each finding of research misconduct:
  - identify whether it was falsification, fabrication, or plagiarism;
  - identify whether it was intentional, knowing, or in reckless disregard;
Policies and Procedures

SECTION: Academic Concerns

NO. 4.2.2.

CHAPTER: Faculty

ISSUED: 1/28/88
REV. A 8/31/95
REV. B 11/29/01
REV. C 2/15/06
REV. D 5/15/13
REV. E

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- summarize the facts and analysis that support the conclusion;
- consider the merits of any reasonable explanation by the Respondent(s);
- identify the specific funding support;
- identify whether any publications need correction or retraction;
- identify the person(s) responsible for the misconduct; and
- any other corrective action recommended.

- Other Support. List any other funding support or known applications or proposals for support that the Respondent(s) have pending with any Federal agency or private sponsor.

ii. Opportunity for Comment
   1. Respondent(s). The Respondent(s) shall be given a copy of the draft investigation report, along with a copy of (or supervised access to) the records and evidence on which the report is based. The Respondent(s) shall have 30 days from date of receipt of the report to submit any comments to the Ad Hoc Investigative Committee.
   2. Complainant(s). At the discretion of the Ad Hoc Investigative Committee, the Complainants may be given a copy of the draft investigation report or relevant portions of that report. The Complainant(s) shall have 30 days from the date of receipt of the report to submit any comments to the Ad Hoc Investigative Committee.

iii. Final Report. The Ad Hoc Investigative Committee shall issue its final report, which shall contain all of the information outlined in section e.i. above, any written comments received from the Respondent(s) and/or Complainant(s) within the time period set forth in paragraph 5.b above, and the Ad Hoc Investigative Committee’s consideration of and response to any comments received from the Respondent(s) or Complainant(s). A copy of the final report shall be given to the Respondent(s), and the Research Compliance Officer, redacting identities of any research subjects. A copy of the final report shall also be given to the Provost, the Respondent(s)’ Dean, Administrator or Supervisor, and the Office of General Counsel, redacting the identity of Complainant(s), witnesses, and any research subjects.

20. Institutional Actions
   a. Finding of Research Misconduct. If the alleged research misconduct is substantiated by thorough investigation of the Ad Hoc Investigative Committee, the recommendations of the Ad Hoc Investigative Committee contained in the final report may be implemented and the following actions, if not already recommended by the Ad Hoc Investigative Committee in its final report, may be taken:
   i. Restitution of funding as appropriate or if required by the agency or contract.
ii. Withdrawal of abstracts and papers emanating from the questioned research, and notification of editors of journals and publications that published previous abstracts and papers concerning the research, if the Ad Hoc Investigative Committee concludes that substantiated research misconduct makes such abstracts and papers of questionable validity. The Dean is authorized to request/direct such actions if the researcher(s) involved fail(s) to do so within a reasonable time after the Dean directs such actions.

iii. Appropriate action (including interim administrative actions) to terminate or alter the status of Respondent(s) whose research misconduct is substantiated, or to impose other sanctions deemed appropriate under the circumstances.

iv. The Dean, the Provost, and the President of the University shall consider, in consultation with the General Counsel, release of information about the research misconduct to the public and/or press, particularly where public funds were used in support of the research affected by the research misconduct.

b. No Findings of Research Misconduct. If the Ad Hoc Investigative Committee finds that there was no research misconduct, efforts shall be undertaken as and if necessary to restore the position and reputation of the Respondent(s).

c. Cooperation with Federal Agencies. Creighton shall cooperate with any Federal agency or its designee during its oversight review or administrative hearings or appeals related to any allegation of research misconduct, including, but not limited to, providing all research records and evidence in Creighton University’s control, custody, or possession, and access to all faculty, staff, and students.

21. Notices

a. Notice to Applicable Funding Agencies of Findings and Actions. The Research Compliance Officer shall be responsible for giving notice to the applicable Federal agency funding the research that is the subject of the research misconduct investigative proceedings or its designee once they are complete. The notice shall be sent immediately after the final report is issued and shall include:

- A copy of the final investigative report and all attachments (redacting identities of research subjects, as applicable);
- A statement of whether or not research misconduct was found, and if so, who committed the misconduct;
- Whether Creighton accepts the Ad Hoc Investigative Committee’s findings; and
- A description of any pending or completed institutional actions taken against the Respondent(s).
Policies and Procedures

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b. **Other Notices to Applicable Federal Funding Agencies.** The Research Compliance Officer shall notify the applicable Federal funding agencies or their designee(s), in advance, if it is planned to close a research misconduct proceeding at the inquiry or investigation stage on the basis that the Respondent(s) has admitted guilt, the Respondent(s) has agreed to settle the case, or for any other reason other than the closing of the case during the inquiry stage on the basis that an investigation is not warranted.

22. **Maintenance of Research Records and Evidence Related to Research Misconduct Proceedings**

a. **Maintenance of Records of Research Misconduct Proceedings.** Unless custody has been transferred to the applicable Federal agency or the Federal agency has advised, in writing, that the information no longer needs to be retained, the following records of research misconduct proceedings shall be maintained for 7 years after completion of the internal research misconduct proceeding or any Federal agency proceeding involving the research misconduct, whichever is longer:

- The records secured for the research inquiry and investigation, except to the extent it is subsequently determined that those records are not relevant to the inquiry or investigation or that the records duplicate other records that are being retained;
- The documentation of the determination of irrelevant or duplicate records;
- The inquiry report and final documents (not drafts) produced in the course of preparing the inquiry report, including the documentation of any decision not to investigate; and
- The investigation report and all records (other than drafts of the report) in support of the investigation report, including the recordings or transcriptions of each interview conducted during the investigation stage.

b. **Transfer of Records to Federal Agency.** Upon request of the applicable Federal agency, the Research Compliance Officer shall transfer custody, or provide copies, of all institutional records relevant to a research misconduct allegation, including research records and evidence, to the requesting Federal agency.

23. **Role of the Office of General Counsel**

Throughout the process of handling an allegation of research misconduct, the Research Compliance Officer, Dean(s), and Ad Hoc Committee members shall consult with the Office of General Counsel for advice and to ensure compliance with this policy and applicable law. Individuals serving in any of these capacities are encouraged to seek legal guidance regarding any procedural question, particularly in connection with the preparation of written reports of actions taken, or before any action is taken with respect to any person believed to have made an accusation of misconduct in bad faith. Any contact with or inquiry to the University from a lawyer outside the University, including contacts and inquiries from legal representatives of any Federal, state, or local agency, must be referred to the Office of the General Counsel. The Research Compliance Officer and/or Dean(s) must also consult the Office of General Counsel prior to any communications with Federal agencies.
A representative of the Office of General Counsel may attend meetings of any Ad Hoc Committee as determined necessary by the Office of General Counsel in consultation with the Research Compliance Officer and Dean(s). A representative of the Office of General Counsel must be present at any meeting attended by counsel for the Respondent(s), if any.

**ADMINISTRATION**

The Dean(s) of the affected school/college and the Research Compliance Officer are responsible for administering this policy when there is an allegation of research misconduct. The Dean(s) of the affected school/college shall report any final action taken under this policy to the Provost, General Counsel, and the Research Compliance Officer.

**AMENDMENTS OR TERMINATION OF THIS POLICY**

Creighton University reserves the right to modify, amend, or terminate this policy at any time.
PURPOSE

The Intellectual Property Policy is to define the conditions for ownership, legal protection, licensing, and development of any intellectual property conceived or first reduced to practice by any Creighton University associated personnel. Intellectual property exempt from this policy is defined, and the division of any income resulting from the development if intellectual property is defined.

POLICY

A. **Applicability:** The Intellectual Property Policy of Creighton University is applicable to all intellectual property conceived or first reduced to practice, in whole or in part, by any full-time or part-time faculty, staff, students, contractors, commissionees, non-employees participating in research projects (visiting faculty, industry personnel, fellows, etc), or others, with more than incidental use of University resources, including personnel, facilities, equipment, services, supplies, trade secrets, employment time (based on a 40 hour week), or funds paid by the University, whether for reimbursement, direct compensation, or by contract. All personnel shall agree as a condition of employment, or of undertaking investigation and development activities, at Creighton University to the conditions in the Intellectual Policy Agreement for Creighton University Personnel (Form OTT-1)(APPENDIX I). This Policy shall be contractually incorporated into the Handbook for Faculty, and Form OTT-1 shall be signed by any non-faculty individuals who may develop intellectual property. Intellectual property shall come under the provisions of this Policy whenever the developer's duties include research and investigation, and the intellectual property developed arose during the course of such investigation and is relevant to the field of inquiry in which the developer was employed, or when the development involved the use of University resources. This Policy **shall not apply** to intellectual property developed for which no substantial University resources or funds were used, which was developed entirely on the developer's own time, which does not relate to the field of the developer's University employment, which does not result from work performed by the developer for the University.

B. **Third Party Arrangements for Research and Development:** Whenever grants, contracts, consulting arrangements, commissions, or agreements, verbal or written, are made or signed to support research or development or clinical trials with other teaching and research institutions, business, industry, governmental agencies, or other third parties, such agreements shall contain intellectual property clauses conforming to this Policy governing the ownership, licensing, and control of any resulting intellectual property. All such agreements shall use agreed standard clauses or shall be cleared through the Director, Office of Technology Transfer. Any agreements with third parties not in conformance with this policy shall be approved in advance by the University.
Public Law 96-517, the Patent and Trademark Amendments Act of 1980, as amended by Public Law 98-620, gives nonprofit organizations and small businesses the right of first refusal to the title to inventions made during the performance of government grants and contracts, with some limited exceptions. If the University does not diligently pursue protection and/or licensing, the invention shall then be referred to the Federal sponsoring agency, and the developer may then request assignment of title from the Government agency. The government shall be given an irrevocable, nonexclusive, royalty-free license. Under the Copyright Act commissioned works of non-employees are owned by the creator, and not by the commissioning party, unless there is a prior written agreement to the contrary. Thus all agreements, commissions, and contracts, shall have provisions providing for the ownership of all copyrightable materials.

C. Ownership of Intellectual Property: The University shall own, or shall be assigned title by the developer, to all intellectual property rights for intellectual property as defined in this Policy, i.e. patents, copyrights, or trademarks, conceived or reduced to practice, in whole or in part, by any personnel directly or indirectly using more than incidentally any University resources, unless specifically exempted by this Policy. Whenever a project is undertaken which may possibly develop intellectual property where ownership and rights may be in question, initial discussion should be held between the developer and the Chair and/or Dean, and an understanding developed and recorded with regard to the intellectual property rights. The developer, or the University, shall each grant the other an irrevocable, nonexclusive, royalty-free, paid up license to the intellectual property for internal, noncommercial use. The owner of the intellectual property shall diligently pursue securing patent, copyright, or trademark protection and licensing for commercial development, but if the owner is not interested in securing protection or developing licensing, or is not diligent in its pursuit, the other party shall have the right to request assignment of ownership to pursue such protection and/or licensing at their own expense. Such assignment shall be granted unless there are reasonable grounds for refusal. Such assignment shall be requested and granted within one year of disclosure, or within nine months of publication or public availability. If the owner pursues protection in the United States the developer may request permission to pursue foreign protection rights separately, and such permission shall be granted if the owner does not diligently pursue such rights. The owner may waive, assign, license, or transfer in the whole, or in part, any of these rights at any time. [Note: Many foreign patents require application prior to publication or public use, although United States law permits one year.] The University agrees that the developer(s) collectively are free to place intellectual property in the public domain, if in the best interest of technology transfer, provided this is not in violation of the terms of any agreements that supported or related to the work.
Policies and Procedures

SECTION: Academic Concerns

CHAPTER: Faculty

POLICY: Intellectual Property

D. Definition of Intellectual Property: Intellectual property for the purposes of this Policy, shall be defined as:

1. **Invention(s):** A novel and useful idea relating to a process, a machine, an article of manufacture, a compound, the composition of matter, or an apparatus or improvement thereof made or conceived by the developer. Inventions include new and improved devices, systems, circuits, chemical compounds, mixtures, bioengineered organisms, etc.

2. **Copyrights and Similar Materials:** Copyrights are the protections provided various forms of written, visual, electronic, and artistic expression, including most software (a set of ordered instructions or programs used to control the operations of a computer). [Note: Some software may be patentable.]

   a. **Excluded Items:** The following classes of intellectual property are excluded from the disclosure, ownership, and royalty distribution provisions of this Policy, unless they are works-for-hire, or institutional projects specifically and substantially directly funded by the University, as defined in 4.b.(2) and (3) following. These excluded classes, whether in print, video, or electronic form, are books, articles, computer software, and similar works intended to disseminate the results of academic or scholarly activities, including dissertations, papers, articles, teaching materials, and syllabi. Similarly excluded are popular nonfiction books, novels, poems, musical compositions, art works, and other works of artistic imagination. Copyrights on these excluded classes of intellectual property, unless works-for-hire, or specifically and substantially directly funded by the University, shall vest in the creator with no requirement for disclosure or distribution of royalties to the University. If copyrights of excluded items vest in the University by law, the University shall, on request, assign such copyrights to the creator(s) of such works. It should be noted that in the majority of instances of published material that the publisher requires that ownership of the copyright be assigned to the publisher prior to publication, and an agreement on the split of royalties is then negotiated.

   b. **Directly Funded Projects (Institutional Projects):** It is agreed that for all intellectual property arising from sponsored agreements or other research, or from scholarly projects, specifically and substantially directly supported by University funds, that ownership of copyrights of works resulting from such projects shall vest in or be assigned to the University. Royalty income from such projects shall ordinarily be distributed as in F. following. This section shall not apply unless there is an agreement in place between the investigator and the University regarding such specific and substantial direct support and the ownership of any resulting copyright(s).
c. **Works-for-Hire:** Ownership of works created on projects on which the employee was employed and specifically directed by the University as a part of the employment or contractual agreement to invent or develop such works, i.e. works-for-hire, shall vest in the University, and shall not be subject to royalty proration under this Policy. This is true regardless of whether or not the work is developed in the course of sponsored research, nonsponsored research, or nonresearch activities. Examples are the development of computer software for specific purposes.

3. **Trade Marks:** Trademarks and service marks are distinctive words or graphic symbols identifying the source, product, producer, or distributor of goods or services. Any trademark or service mark that results from activities at or through the University shall be owned by the University.

4. **Trade Secrets:** Any proprietary intellectual property arising out of University work as defined in this Policy that is not patented, copyrighted, or otherwise protected, whether or not it is patentable or copyrightable, shall be owned by the University. Trade secrets are properties which are not generally known or accessible, and which give competitive advantage to the owner. Since trade secrets are essentially not legally protected, and the only protection is restriction of dissemination and signed secrecy agreements, this concept should rarely apply in the University setting.

E. **Disclosure:** All intellectual property developed by any full-time or part-time faculty, staff, students, contractors, commissionees, non-employees participating in research, or others at Creighton University shall be disclosed to the Director, Office of Technology Transfer as soon as the invention or intellectual property is conceived or reduced to practice. The disclosure shall describe the invention or intellectual property and it uses, list the inventors, and describe the circumstances leading to the invention and subsequent activities. Disclosure need not be made on copyrightable items clearly excluded in 4. preceding from the definition of intellectual property. Disclosure shall be made for all potentially patentable inventions, nonexcluded copyrights, trademarks, and other intellectual property developed by individuals subject to this policy, regardless of the source of funding or the use of University resources, in order to clearly determine ownership. Disclosure shall not be made to the sponsor of the research or development until after submission to the Director, Office of Technology Transfer.

The Director shall determine on all disclosures received whether to pursue protection and licensing, or whether to assign ownership to a sponsor or the developer, on request. All developers shall cooperate fully with the Director in supplying and executing all necessary documents for the approved course of action.
### Policies and Procedures

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**F. Royalty Distribution:** All income received from royalties and/or licensing or sale of any intellectual property not excluded by this Policy, by the University, or by the developer of the intellectual property, regardless of ownership, shall be distributed successively as follows:

1. Directly assignable expenses, outside of the University and/or the developer, for applications for and securing of protection, or for licensing.
2. A 15% technology transfer fee for developments administered by the Office of Technology Transfer.
3. Payments of contractually required amounts to sponsors or other institutions participating in the development of the Intellectual Property.
4. Payment to the developer(s), split according to their degrees of involvement, of 50% of the net return (total minus 1., 2., and 3.).
5. Payment to the University of 25% of the net return (total minus 1., 2., and 3.).
6. Payment to the University School(s), split according to their degrees of involvement, in which the developer(s) is appointed, of 12.5% of the net return (total minus 1., 2., and 3.).
7. Payment to the University Department(s), split according to their degrees of involvement, in which the developer(s) is appointed, of 12.5% of the net return (total minus 1., 2., and 3.).

**Note 1:** When there is more than one developer, or more than one School or Department, payments shall be prorated based on the contribution of each as agreed between the parties and the Director of the Office of Technology Transfer, and as approved by the President.

**Note 2:** Funds designated for the University, School, and Department shall be used to support the development of further intellectual properties and research. Funds for the University shall be administered by the President, those for the School by the Dean, and those for the Department by the Chair.

**Note 3:** In the case of intellectual property developed by a group where the distribution of royalty to individuals would be impractical or inequitable, such as a laboratory project, the developer(s) share shall be allocated by the Dean to a fund for the developing unit.
Policies and Procedures

SECTION: Academic Concerns

CHAPTER: Faculty

POLICY: Intellectual Property

G. **Publication:** The policy of the University is openness in research, and the ability of investigators to publish research results. Investigators shall not enter into projects requiring secrecy without the specific permission of the Dean. A project requiring secrecy is defined as one in which the sponsoring or granting documents are not freely publishable, access to security classified information is necessary to carry out the research, or one in which there is a reasonable expectation that any documents generated will be restricted by an outside sponsor from publication for a period in excess of 90 days. Secrecy based on reasonable provisions to protect the rights and privacy of all individuals is acceptable. Provisions from a sponsor requiring submission of publications for review and comment, or for patenting purposes, are acceptable provided there is no reason to expect that the sponsor would attempt to suppress publication or require substantive changes. If confidential information has been made available to the investigator the confidentiality of such information may be protected, and the person furnishing such information may require submission of any manuscript for review and comment and deletion of specific items constituting disclosure of such confidential information within 90 days. It should be noted that in the United States application for a patent must be submitted within one year of publication or public use of the invention, but for many foreign countries patent applications must be submitted prior to publication or public use.

H. **Intellectual Property Board:** The President shall appoint a Board of nine to twelve voting members, and shall designate a Chair, which shall review and monitor on an ongoing basis the Intellectual Property Policy and the activities of the Office of Technology Transfer, and shall offer advice and consultation to the Director. The Board shall review specific cases and problems encountered. All cases of significant disagreement between the Director of the Office of Technology Transfer and any developer of intellectual property with regard to the applicability of the Intellectual Property Policy, or its application, shall be referred to the Board for consideration. The Board shall recommend an appropriate resolution, which if not acceptable to both parties, shall be referred to the supervising Dean designated by the President, and then through the appropriate University Vice President to the President for resolution. The Board shall consist of at least one member from each of the Schools and Colleges of the University. In addition, the Vice-President for Administration and Finance, and the Director of the Office of Technology Transfer shall be ex-officio members without vote. Appointments to the Board shall be for staggered three year terms.

I. **Functions of the Office of Technology Transfer (OTT):** The Director, OTT, shall report to the President of Creighton University, who may delegate in writing immediate supervision and ongoing monitoring to an appropriate Dean. The Director of the Office of Technology Transfer shall maintain liaison with, and provide advice and consultation to, faculty and staff to identify intellectual property which is potentially patentable, copyrightable, or registerable as a trademark or service mark, and promote its protection, technology transfer, and licensing. The Director shall represent the University in accepting those developments in which the University has a significant interest, and shall diligently pursue their protection, transfer, and licensing. The University shall pay all necessary fees and costs for protection and licensing of accepted developments. For those developments to which the University does not wish to make a commitment, the Director shall promptly assign such developments, on request, to the developer, sponsor, or other appropriate party.
The Director, OTT, shall provide reasonable amounts of advice, consultation, and assistance to faculty and staff to assist developers in protecting, transferring, and licensing developments which do not come under the Intellectual Property Policy, or which have not been accepted by the University. The developer shall be responsible for all necessary fees and costs for protection, transfer, and licensing of developments not accepted by the University. There shall be no charge for reasonable amounts of advice, consultation, and assistance from OTT.

For accepted developments OTT shall prepare a customized marketing plan and establish an appropriate action plan. The major goals shall include:

1. to transfer technology to the commercial sector for public benefit.
2. to establish sources of unrestricted income to be used for institutional purposes.
3. to encourage industry to support the direct costs of research and training.
4. to generate consulting and science-advisory opportunities for the faculty.
5. to assist in the development of local and regional enterprises.

The Director, OTT, shall advise and recommend to the University Contracting Officer policy and its implementation for the protection and sharing of intellectual property ownership, technology transfer, and licensing for all University grants, contracts, and agreements.

The Director, OTT, shall be responsible for the protection, transfer, and licensing activities associated with all University technologies, shall administer the licenses, and maintain records regarding the receipt and distribution of all royalty, licensing, and other related income. The Director shall make recommendations with regard to all cases of disputed ownership, licensing, or income distribution concerning intellectual property developed by any full-time or part-time faculty, staff, students, contractors, commissionees, non-employees participating in research projects, and others at Creighton University. All unresolved disputes shall be referred to the Intellectual Property Board for consideration and recommendations for resolution. Those issues not satisfactorily resolved shall be referred to the supervising Dean designated by the President, and then through the appropriate University Vice-President to the President, for resolution.
SCOPE

The Intellectual Property Policy applies to all intellectual property (inventions, devices, creations; written, visual, electronic, software, or artistic expressions; trademarks; or trade secrets) conceived or first reduced to practice. Excluded copyrighted materials are specified. It applies to all full-time or part-time faculty, staff, students, contractors, commissionees, or non-employees (visiting faculty, industry personnel, fellows, etc.) participating in research projects at Creighton University, as a condition of employment or research participation.

ELIGIBILITY

All full-time or part-time faculty, staff, students, contractors, commissionees, or non-employees (visiting faculty, industry personnel, fellows, etc.) participating in research projects at Creighton University, are covered immediately and continuously on an ongoing basis, as a condition of employment or participation.

DEFINITIONS

All terms are defined in the Intellectual Property Policy in paragraph D.

ADMINISTRATION AND INTERPRETATION

The Intellectual Property Policy is administered by the Office of Technology Transfer. The Director, Office of Technology Transfer, reports to the President, Creighton University, who may delegate, in writing, immediate supervision and monitoring to an appropriate Dean. All disputes between developers of intellectual property and the Director, Office of Technology Transfer shall be referred to the Intellectual Property Board, appointed by the President, for consideration and a recommended solution. If the recommendation is not mutually acceptable it shall be referred through the Supervising Dean to the appropriate Vice-President and to the President for resolution. Questions regarding the interpretation of the Intellectual Property Policy should be referred to the Director, Office of Technology Transfer, or the University Counsel.

AMENDMENTS OR TERMINATION OF THIS POLICY

Creighton University reserves the right to modify, amend, or terminate this policy at any time. The Intellectual Property Policy constitutes a contract with all University faculty through the current edition of the Handbook for Faculty, and is binding with regard to all development of intellectual property disclosed to the University, undertaken by mutual agreement between the developer and the University, or developed under external contracts in place, up to the effective date of modification, amendment, or termination. Intellectual Policy Agreements for Creighton University Personnel may also be in place, which are subject to modification, amendment, or termination in the same manner as set forth above.
APPENDIX I

Intellectual Policy Agreement for Creighton University Personnel

In consideration of my employment or continued employment by Creighton University, my contractual relationship with Creighton University, the receipt of remuneration from Creighton University, participation in projects administered by Creighton University, access to or use of facilities provided by Creighton University, and/or other valuable considerations, I hereby agree as follows:

1. I shall disclose to Creighton University all potentially patentable inventions conceived or first reduced to practice in whole or in part in the course of my University responsibilities, or with more than incidental use of Creighton University resources. I further agree to assign to Creighton University all of my rights, title, and interests in such potentially patentable inventions, to execute and deliver all documents, and do any and all things necessary and proper on my part to affect such assignment.

2. I shall disclose and assign or confirm in writing to Creighton University all my rights, title, and interests, including any associated copyrights, in and to copyrightable materials created, except as excluded by the Creighton University Intellectual Property Policy:
   a. in the course of any research, grant, or contract, or other agreement entered into by Creighton University, if the terms of the agreement require creation of copyrightable materials, or require some interest in them be conveyed to Creighton University, to the sponsor, or to any other party;
   b. in the course of my employment (that is, as a work-for-hire, or as an institutional work); or
   c. in the course of a project specifically and substantially directly supported by University funds where an agreement is in place between the investigator and the University regarding such support and the ownership of any resulting copyrights.

3. I am now under no consulting or other obligations to any third person, organization or corporation in respect to rights in inventions or copyrightable materials which are, or could reasonably be construed to be, in conflict with this agreement.

NOTE: If you do have an agreement with another employer, or anyone else, that would apply to copyrightable materials or to potentially patentable inventions conceived or first reduced to practice, in whole or in part, with more than incidental use of Creighton University resources, do not sign this form. You must consult with the Dean of your School or College for resolution of any conflicts before using any Creighton University resources, and to develop specific written exceptions to this agreement prior to signing.
4. I shall not enter into any agreement creating copyright or patent obligations in conflict with this agreement. I further agree to be bound by the terms of any grants, contracts, or other agreements entered into by Creighton University in which I am an investigator or participating worker, regarding patent and copyright obligations.

5. This agreement is effective as of the date of signing, or of hire or entering into any covered contractual relationship, and is binding on myself, my estate, heirs, and assigns.

Signed this _________ day of ______________, ________

(Signature)      (Printed or Typed Name)

_____________________________  _____________________________  _____________________
(Title)    (Department)   (Social Security Number)

NOTE: This agreement does not apply to any invention which is an invention for which no significant Creighton University equipment, supplies, facilities, or trade-secret information were used, and which was developed entirely on the developer's own time, and neither (a) related to Creighton University research, nor results from any work performed by the developer for Creighton University.

Original to Office of Technology Transfer, copy to signer.

Form CU OTT-1

APPENDIX II

Course Materials for Distance Learning: Creation, Use, Ownership, Royalties, Revision and Distribution of Electronic-Based Course Materials

Introduction

The purpose of this appendix is to protect the rights of both the faculty member and the University in the creation and use of distance learning course materials. Since the demand for distance learning appears to be increasing and the continuing creation of electronic-based course materials seems likely, it is important to address the issues raised by the creation, use and distribution of various forms of electronic-based course materials and to clarify the rights and responsibilities of the parties involved.
General Guidelines

- Reporting Authority. It is likely that a faculty member creating distance learning course materials will be doing so in the school/college of his or her primary appointment. If a faculty member develops distance learning course materials for another school or college, responsibility to his/her primary Dean is not waived. This policy describes the obligations of faculty members to report intentions to develop distance learning course materials to his/her primary Dean prior to negotiating with any other entity.

- Initiation of Distance Education Course Materials. As a general rule, faculty members should meet with their Dean (Dean of the school or college where his or her primary appointment resides) or the Dean's designee prior to creating electronically-based course materials for distance learning in order to reach an agreement as to the appropriate category classification. (See more on this below)

- Copyright Ownership. The University Intellectual Property Policy (4.2.3) recognizes that in most instances faculty members own copyright in the scholarly works they create. Faculty members thus normally hold copyright in the electronic-based course materials they create on their own initiative. Creighton University's Intellectual Property Policy recognizes University ownership of copyright in works created under contract as institutional projects or works-for-hire. Any owner of copyright in electronic-based course materials may secure copyright registration; joint owners may, but do not have to, agree to bear responsibility for enforcement of the copyright. Copyright Law controls ownership of works of students. Students own copyright in their works and creators of new works incorporating student materials must obtain their permission. Specific copyright ownership rights are addressed in Categories I-IV below.

- Royalties. Royalties will only be paid for electronic-based course materials for courses delivered to students in classes that are outside the faculty member's scope of employment including electronic-based course materials used in programs marketed or licensed to outside organizations. Absent a contract specifying to the contrary, specific division of royalties is addressed in Category I-IV below. When multiple faculty members create electronic-based course materials for which a royalty is to be paid, the faculty members shall determine by prior written document the division of royalties. Absent a written document of division of royalties, the faculty members shall divide their share equally.

- Contributed Materials. Liabilities result from use of materials copyrighted by others, and use of voice and image files without seeking appropriate permissions. It is the policy of the University that all faculty comply with the law, including copyright and privacy laws; therefore, it is the responsibility of the creator(s) of electronic-based course materials to obtain all permissions and releases necessary to avoid infringing copyright or invading the personal rights of others.
• Protecting the Work. Faculty members will decide registration and enforcement action to protect works they own. Creighton University will determine whether to register the copyright and will determine enforcement action of the works it owns, either solely or jointly.

• Conflict of Commitment. Nothing in the Creighton University Intellectual Property Policy as amended by this Appendix II is intended to interfere with a faculty member’s duties for the University generally set out in Section III C of the Faculty Handbook. Nor is it intended to undermine the authority of the faculty member’s Dean to assign courses and duties to faculty member in his/her discretion. While employed, a faculty member may not engage in any activity which competes with the business of the University.

• Retention of Nonexclusive License. Except in Category I below, the University shall retain a non-exclusive educational license in perpetuity to reproduce and use the electronic-based course materials in teaching University classes. Compensation to the faculty member for use of the course shall be as specified in Categories I-IV below.

• Termination of Agreement. Either the University or the Creator may terminate a License Agreement without cause at any time upon ninety days prior written notice to the other party.

• End of Employment. Each License Agreement shall survive the end of employment for a period of three years unless terminated as described in this policy. However, the License Agreement may be extended beyond that date by mutual agreement of both the University and the Creator.

• Precedence. In the event of a disagreement of interpretation between this Appendix and the Intellectual Property Policy, the Intellectual Property Policy takes precedence.

Definitions:

Copyrightable Creation: Original work that has been fixed in any tangible medium of expression from which it can be perceived, reproduced, or otherwise communicated, either directly or with the aid of a machine or device. A Copyrightable Creation includes such creations as book, journals, musical works, videos, multimedia products, sound recordings, pictorial or graphical works, etc. A copyrightable creation may be the product of a single creator or a group of creators who have collaborated in the creation of the work.

Copyright protects the expression of an idea, not the idea itself. Such expression must be in some retrievable form such as handwriting, type, computer disk, magnetic tape, or other storage medium. Copyright covers the expression in literary, artistic, or musical works, websites, video recordings, sound recordings, photographs, and sculpture. Copyright automatically comes into being when the idea is fixed in a tangible medium of expression, but the protection of copyright cannot be enforced without registration of the copyright.
Course: Any class or instructional unit offered by the university. A course may be for-credit or not-for-credit, required or not required for a degree or certificate, and includes classes or instructional units sponsored by the University for professional or personal development. A course does not include multi-media developed by support personnel.

Course Materials: Materials including, but not limited to, lectures, recorded answers to questions, assignments, visual aids, and other materials presented by the course creator and/or instructor including, but not limited to text, images, syllabi, diagrams, graphs, multimedia presentations, videos, exercises for collaboration, simulations, and group projects that are created to illustrate or explain the subject matter.

Creator: Person whose ideas become fixed in a tangible medium. Merely carrying out work that is directed by another does not meet this definition.

Distance Education/Distance Learning (as used in this appendix): Instruction and use of electronic-based course materials where the teacher and the student may be separated geographically, so that face-to-face communication is absent for some or all students taking the course; communication is instead by one or more technological media. This communication consists of live or recorded audio and/or visual presentations, and/or material using the Internet, direct signal or cable transmission by telephone line, fiber-optic line, digital and/or analog or other electronic means, now known or hereinafter created, and utilized to teach any course originating or sponsored by the University.

Electronic-Based Course Materials: Materials, either in print, audio, video or electronic form used in conjunction with a distance learning course.

Scope of Employment: Scope of employment includes the duties or activities attached to the employment position or bearing a reasonable relationship to it. Duties may be listed in a job description or employment contract, or may be assigned by one's supervisor, or may be generally understood expectations of a discipline, field or trade. The duties may be performed during normal business hours and at University facilities, but the time and site of their performance do not necessarily determine ownership of the product of the work.

Specific Categories Assigning Ownership and Royalties

Development of Course Materials in School or College of Faculty Member's Primary Appointment
As a general rule, faculty members should meet with their Dean (Dean of the school or college where his or her primary appointment resides) or the Dean's designee prior to creating electronically-based course materials for distance learning in order to reach an agreement as to the appropriate category classification. Once the category has been determined, a written license agreement shall be executed by the faculty member and the University. The Dean has the responsibility to establish the category. In the event of an unresolvable dispute, appeal may be made to the Intellectual Property Board for final resolution. It is understood that in some circumstances this category classification may change based on a modification in University support for the project. Changes in classification require agreement between the Dean and the faculty member, and a new license agreement will be executed to supersede the one that is in place.
Development of Course Materials Outside of the School or College of Faculty Member's Primary Appointment

In cases where the electronic course materials are being developed for a school or college other than the faculty member's primary appointment, his or her primary Dean must be notified prior to reaching any contractual arrangement. The Dean may approve, may restrict the use of University resources involved in the project, or deny permission for the faculty member to participate.

If approval from the faculty member's primary Dean is secured, the faculty member should meet with the contracting entity, normally a Dean or his or her designee, in order to reach agreement as to the appropriate category classification for the course materials. Once the category has been determined, a written license agreement shall be executed by the faculty member and the University. The contracting Dean has the responsibility to establish the category. In the event of an irresolvable dispute, appeal may be made to the Intellectual Property Board for final resolution. The faculty member has the responsibility to provide his or her primary Dean with a copy of the license agreement. It is understood that in some circumstances this category classification may change based on a modification in University support for the project. Changes in classification require agreement between the Dean and the faculty member, and a new license agreement will be executed to supersede the one that is in place.

Right to Establish Further Guidelines

Individual academic and administrative units may wish to establish further guidelines, consistent with this policy, to clarify the distinction between minimal and substantial for that particular unit.

Category I – Totally Faculty Generated

Description of Individual and University Contribution:
The work resulted from an individual’s efforts with no use of University resources. Additionally the individual developed the work on his/her own time.

Examples:
1. A faculty member in Sociology works with a publishing company to create a Web-based course. The publishing company provides 700 hours of instructional design and production support and the course is mounted on the company’s server. All of the work is done on the faculty member’s own time, but some of the development is done on weekends using the faculty member’s office computer. Creighton University-licensed development software that is available throughout the department is also used. The course is mounted on a commercial server.

2. A professor in forensic psychology is approached by the publishing arm of a learned society to create a CD containing 2,000 images of evidence that this professor has photographed in preparing for classes over the years. The professor took the photographs on weekends using his/her own camera and film, but on the department’s copystand. The learned society creates and markets the CD.
Ownership and Compensation

The individual owns the copyright, may receive compensation for work, and retains all distribution rights. This category is substantially similar to "Excluded Items" in Section D.2.a. of the Intellectual Property Policy. Such distribution and compensation rights are governed by the "conflict of commitment" statement in the Faculty Handbook (Section III. C. 1.) and as required by law. A Faculty Member may not engage in any activity which conflicts with his/her full/time commitment to the University and which conflicts or competes with the business of the University in the judgment of the President and his/her Dean.

**Category II– Minimal University Resources**

**Description of Individual and University Contribution:**
The work resulted from the individual's efforts including the use of minimal routine resources of the university, including assigned or general-use office equipment and computers, libraries, generally-available information resources, photocopiers, local telephone, office supplies, limited administrative/clerical support or limited use of shared university resources. The majority of the work was completed on the faculty member's own time (outside his/her usual business hours). Use of the university's dedicated laboratories, computer centers, media centers and/or dedicated equipment is considered more than minimal use of University's resources.

Examples:
1. A faculty member works with Digital Inc., a Web course publishing company, to put the course, "Serving an Aging Population," totally on the Web. The University provides funds to purchase time from the Media Television to videotape two hours of lecture to be streamed as part of the course. In addition, the University’s Media Services checks out to the faculty member one of two digital recording workstations for a period of two weeks. Digital Inc. spends over 300 hours recording materials provided by the faculty member and creating the Web course, and mounts the course on their server. The faculty member works on the project almost exclusively on his/her own time.

2. An adjunct faculty member who teaches Accounting Principles for Non-Profit Agencies for the University volunteers to put half of the course on the Web. The University provides 30 hours of training on WebCT, the Web platform utilized. The University also provides twenty hours of assistance in creating a Power Point Presentation to be used as part of the course. The adjunct faculty member spends 200 hours creating the course on his/her own time. The course is mounted on the University’s server.

**Ownership and Compensation**
The individual faculty member owns the copyright and has the right to distribute it and receive compensation for any distribution outside the University's course delivery, with permission of the individual's Dean or his/her designee to ensure compliance with the conflict of commitment clause in the Faculty Handbook (Section III. C. 1.). The University retains a non-exclusive royalty-free educational license in perpetuity to use the work as part of a Creighton University Course. The University also retains a non-exclusive royalty-bearing commercial license to market the Course outside the University.
If licensed for commercial purposes either by the University or the faculty member, the University and the faculty member will each receive a percentage of the royalty as negotiated. In case of multiple creators, the creators will share the royalty according to the "Royalties" statement in General Guidelines above. The Intellectual Property Policy Board will resolve disputes regarding compensation. The Intellectual Property Policy Board’s resolution of the dispute will be final.

**Category III– Substantial University Resources Are Provided**

**Description of Individual and University Contribution:**
The work resulted from the individual’s efforts with substantial University resources above and beyond those normally provided. Use of any University-paid time or funding, or the use of facilities, equipment, staff assistance, and/or significant administrative support that exceeds minimal use, as described above, including use of dedicated laboratories, dedicated computer centers, and dedicated equipment.

Substantial use of University resources occurs when the creation of the work requires use of University resources beyond those widely available to University personnel and students in support of their academic work within their respective departments, colleges, academic or administrative units.

Substantial use requires extensive unreimbursed use of University resources (equipment, computational facilities, laboratory space, studio space, performance space, financial resources or human resources) that are essential to the creation of intellectual property. Incidental use of University resources does not constitute substantial use, nor does extensive use of resources commonly available to all faculty, students, and staff (such as libraries, office space, electronic mail, local telephone, and office computer equipment) nor does extensive use of a specialized facility for routine tasks.

**Examples:**

1. A faculty member volunteers to make his/her department’s "Pharmacokinetics" Course totally available on the Web. The faculty member is provided with a course release in the Spring Semester and paid for a course in the summer to create the product. The faculty member also contributes some of her own time. The University's graphic designers and web developers spend over 100 hours converting course notes to a web-based platform, contributing pedagogical advice to make the web pages effective teaching tools. The course is mounted on the University’s server.

2. The University’s MBA Program decides to offer the degree by taping courses and allowing employees of two corporations to download the courses to view on their own schedules. Three faculty members from the MBA Program will rotate grading and answering questions for each course. A faculty member who teaches Human Resource Management volunteers to offer the first course. During the next year, this faculty member is given a course release each semester and paid for two courses in the summer. The University funds production time in the Media Television for the production of the tapes. Media Services contributes significant hours in digitizing the tapes. The faculty member spends 60 hours over the year of his/her own time designing the course for television delivery. The University mounts the course on its server.
Ownership and Compensation
The individual and the University jointly own the copyright. The University and the Creator each have the right to market the course outside the University, subject to Category III Ownership and Compensation requirements of the Intellectual Property Policy. The University has the right to distribute it and receive compensation. If licensed for commercial purposes either by the University or the faculty member, the University and the faculty member will each receive a percentage of the royalty as negotiated. In case of multiple creators, the creators will share the royalty according to the General Guidelines above.

Category IV – Work Made for Hire – University Assigns Duty to Faculty Member to Create a Work

Description of Individual and University Contribution:
A faculty member of the University was contracted to create a specific product. The University provided all resources for the work. The work was carried out totally within the faculty member’s scope of employment.

Example:
1. The Dean of the School of Nursing assigns a faculty member to a course that will be videotaped and broadcast the next year to sites in five hospitals as part of a new Master’s Program offered by the school. The faculty member is given course releases for the fall and spring semester and is paid a task payment. All of the design and production work is done during working hours. A contract for this work is signed by the faculty member and the University. The faculty member is assigned a .5 FTE research assistant for the academic year. Media Television contributes 250 hours in the design and production of the videotapes.

Ownership and Compensation
The University owns the copyright, has an exclusive educational and commercial ownership and license authority. The faculty member is not entitled to payment of royalty. Since "Work-for-Hire" and "Institutional Projects" require a contract between the faculty member and the University, no license agreement is required.

LICENSE AGREEMENT FOR DISTANCE LEARNING CATEGORY I

This License Agreement (“Agreement”) is made effective as of ___________ by and between ________________, (hereinafter referred to as “Creator”), and Creighton University (hereinafter referred to as “University”). This license agreement pertains to the Electronic-based Course Materials in the course entitled ________________________________.

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Intellectual Property

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Policies and Procedures

SECTION: Academic Concerns

CHAPTER: Faculty

POLICY: Intellectual Property

The parties agree as follows:

To be bound by all of the terms in the University’s Intellectual Property Policy (4.2.3.)

The parties further agree as follows:

1. **Policy Category**: The course fits within Category I of the Policy.
2. **Copyright**: The Copyright is owned by the Creator.
3. **Educational License**: (If applicable) The Creator grants /does not grant Creighton University a non-exclusive educational license to use the work as part of a Creighton University course. If the University uses the work in a course not taught by the Creator, then the University will compensate the creator at a rate of ____ % of the tuition paid by each student in that class. The compensation will be paid at the end of each semester or summer session as applicable. With each compensation payment, the University will submit to the Creator a written report that sets forth the calculation of the amount of the compensation payment. In case of multiple creators, the creators will share their percent royalty as follows:

   ____ % to ______________________________
   ____ % to ______________________________
   ____ % to ______________________________

4. **Commercial License**: The Creator has the right to market the course outside the University, subject to Category I Ownership and Compensation requirements of the Intellectual Property Policy. The Creator permits / does not permit the University to market the course outside the University. If permitted, the University and the Creator will share the royalty as follows:

   ____ % of gross tuition to Creator and ____ % to the University. In case of multiple Creators, the Creators will share their percent royalty as follows:

   ____ % to ______________________________
   ____ % to ______________________________
   ____ % to ______________________________

5. **Term of License**: This license continues in force for three (3) years, with automatic one-year extensions unless this agreement is terminated or modified by either party. Faculty member will update the course material at least ____ times per year. The faculty member’s name will / will not be used with the course material.

6. **Transfer of Rights**: This Agreement shall be binding on any successors of the parties. Neither party shall have the right to assign its interests in this Agreement to any other party, unless the prior written consent of the other party is obtained.
7. **Entire Agreement.** This Agreement and the applicable Creighton University policies contain the entire agreement of the parties and there are no other promises or conditions in any other agreement whether oral or written. This Agreement supersedes any prior written or oral agreements between the parties.

8. **Amendment.** This Agreement may be modified or amended, if the amendment is made in writing and is signed by both parties.

9. **Severability.** If any provision of this Agreement shall be held to be invalid or unenforceable for any reason, the remaining provisions shall continue to be valid and enforceable. If a court finds that any provision of this Agreement is invalid or unenforceable, but that by limiting such provision it would become valid or enforceable, then such provision shall be deemed to be written, construed, and enforced as so limited.

10. **Waiver of Contractual Right.** The failure of either party to enforce any provision of this Agreement shall not be construed as a waiver or limitation of that party's right to subsequently enforce and compel strict compliance with every provision of this Agreement.

11. **Venue.** The parties herein agree that this contract shall be enforceable in Omaha, Nebraska and if legal action is necessary to enforce it, exclusive venue shall be in Douglas County, Nebraska.

12. **Governing Law.** This contract shall be governed by and construed in accordance with the laws of the State of Nebraska.

Creator: __________________________________________________________

Date ____________________, 200_

Dean or Assigned Designee ___________________________________________

Date ____________________, 200_

Vice President for Administration & Finance ___________________________________________

Date ____________________, 200_

**LICENSE AGREEMENT FOR DISTANCE LEARNING CATEGORY II**

This License Agreement ("Agreement") is made effective as of _________ by and between ________________________, (hereinafter referred to as "Creator"), and Creighton University (hereinafter referred to as "University").

This license agreement pertains to the Electronic-based Course Materials in the course entitled______________________________
The parties agree as follows:

To be bound by all of the terms in the University's Intellectual Property Policy (4.2.3.)

The parties further agree as follows:

1. **Policy Category**: The course fits within Category II of the Policy.
2. **Copyright**: The Copyright is owned by the Creator.
3. **Educational License**: The Creator grants Creighton University a non-exclusive, royalty free educational license to use the work, in perpetuity, as part of a Creighton University course.
4. **Commercial License**: The Creator has the right to market the course outside the University subject to Category II Ownership and Compensation requirements of the Intellectual Property Policy. The Creator permits the University to market the course outside the University. The University and the Creator will share the royalty as follows: _____ % to Creator and _____% to the University. In case of multiple Creators, the Creators will share their percent royalty as follows:
   _____% to ___________________________
   _____% to ___________________________
   _____% to ___________________________
5. **Term of License**. This license continues in force for three (3) years, with automatic one-year extensions unless this agreement is terminated or modified by either party. Faculty member will update the course material at least ___ times per year. The faculty member's name will / will not be used with the course material.
6. **Transfer of Rights**. This Agreement shall be binding on any successors of the parties. Neither party shall have the right to assign its interests in this Agreement to any other party, unless the prior written consent of the other party is obtained.
7. **Entire Agreement**. This Agreement and the applicable University policies contain the entire agreement of the parties and there are no other promises or conditions in any other agreement whether oral or written. This Agreement supersedes any prior written or oral agreements between the parties.
8. **Amendment**. This Agreement may be modified or amended, if the amendment is made in writing and is signed by both parties.
9. **Severability**. If any provision of this Agreement shall be held to be invalid or unenforceable for any reason, the remaining provisions shall continue to be valid and enforceable. If a court finds that any provision of this Agreement is invalid or unenforceable, but that by limiting such provision it would become valid or enforceable, then such provision shall be deemed to be written, construed, and enforced as so limited.
10. **Waiver of Contractual Right**. The failure of either party to enforce any provision of this Agreement shall not be construed as a waiver or limitation of that party's right to subsequently enforce and compel strict compliance with every provision of this Agreement.
11. **Venue**. The parties herein agree that this contract shall be enforceable in Omaha, Nebraska, and if legal action is necessary to enforce it, exclusive venue shall be in Douglas County, Nebraska.

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12. Governing Law. This contract shall be governed by and construed in accordance with the laws of the State of Nebraska.

Creator: ________________________________________________
Date ______________________, 200_

Dean or Assigned Designee: ________________________________________________
Date ______________________, 200_

Vice President for Administration & Finance: ________________________________________________
Date ______________________, 200_

LICENSE AGREEMENT FOR DISTANCE LEARNING CATEGORY III

This License Agreement ("Agreement") is made effective as of ________ by and between ____________________________ (hereinafter referred to as "Creator"), and Creighton University (hereinafter referred to as "University").

This license agreement pertains to the Electronic-based Course Materials in the course entitled __________________________________________________________.

The parties agree as follows:

To be bound by all of the terms in the University's Intellectual Property Policy (4.2.3.)

The parties further agree as follows:
1. Policy Category: The course fits within Category III of the Policy.
2. Copyright: The Copyright is jointly owned by the Creator and the University.
3. Educational License: Creighton University retains its non-exclusive, royalty-free educational license to use the work as part of a University course.
4. Commercial License: The University and the Creator each have the right to market the course outside the University, subject to Category III Ownership and Compensation requirements of the Intellectual Property Policy. If licensed for commercial purposes either by the University or the Creator, the University and the Creator will share the royalty as follows: _____% to Creator and _____% to the University. In case of multiple Creators, the Creators will share their percent royalty as follows:
5. **Term of License.** This license continues in force for three (3) years, with automatic one-year extensions unless this agreement is terminated or modified by either party. Faculty member will update the course material at least times per year. The faculty member's name will / will not be used with the course material.

6. **Transfer of Rights.** This Agreement shall be binding on any successors of the parties. Neither party shall have the right to assign its interests in this Agreement to any other party, unless the prior written consent of the other party is obtained.

7. **Entire Agreement.** This Agreement and the applicable Creighton University policies contain the entire agreement of the parties and there are no other promises or conditions in any other agreement whether oral or written. This Agreement supersedes any prior written or oral agreements between the parties.

8. **Amendment.** This Agreement may be modified or amended, if the amendment is made in writing and is signed by both parties.

9. **Severability.** If any provision of this Agreement shall be held to be invalid or unenforceable for any reason, the remaining provisions shall continue to be valid and enforceable. If a court finds that any provision of this Agreement is invalid or unenforceable, but that by limiting such provision it would become valid or enforceable, then such provision shall be deemed to be written, construed, and enforced as so limited.

10. **Waiver of Contractual Right.** The failure of either party to enforce any provision of this Agreement shall not be construed as a waiver or limitation of that party's right to subsequently enforce and compel strict compliance with every provision of this Agreement.

11. **Venue.** The parties herein agree that this contract shall be enforceable in Omaha, Nebraska and if legal action is necessary to enforce it, exclusive venue shall be in Douglas County, Nebraska

12. **Governing Law.** This contract shall be governed by and construed in accordance with the laws of the State of Nebraska.
Academic Concerns

SECTION: 4.2.3.

CHAPTER: Faculty

POLICY: Intellectual Property

Creator: ____________________________________________
Date ________________, 200_

Dean or Assigned Designee: ______________________________
Date ________________, 200_

Vice President for Administration & Finance: ______________________________
Date ________________, 200_
PURPOSE
Creighton University desires to have a fair and uniform policy regarding employment termination rights of Non-Tenure-Track Faculty in grant-funded positions, in whole or in part.

POLICY

A. A full-time NTT Faculty member whose position is supported in whole or in part by grant funds or other non-GCF funding sources shall have the following rights with respect to termination of employment for exhaustion of funds:

1. A faculty member who has completed less than five years of employment (based on the academic year) shall be entitled to receive a minimum three months' written notice of termination of employment and a written statement from the appropriate supervisor that the non-reappointment occurred for financial reasons only, i.e., grant funds' exhaustion.

2. A faculty member who has completed five but less than ten years of employment (based on the academic year) shall be entitled to receive a minimum of six months' written notice of termination of employment and a written statement from the appropriate supervisor that the termination occurred for financial reasons only, i.e., grant funds' exhaustion.

3. A faculty member who has completed ten or more complete years of employment (based on the academic year) shall be entitled to receive a minimum of one year's written notice of termination of employment and a written statement from the appropriate supervisor that the non-reappointment occurred for financial reasons only, i.e., grant funds' exhaustion.

4. A NTT Faculty member with years of employment set out in subparagraphs 1-3 above may apply for other positions at Creighton University, including faculty, staff, and administrative positions according to standard University policies and procedures on hiring.

B. Faculty Employment Agreements for NTT Faculty shall reflect the provisions set forth in this policy.
SCOPE

This policy applies to all full time Non-Tenure-Track Faculty, more particularly described in Article III, Section A(3)(c) of the Handbook for Faculty, hereafter, "NTT Faculty." The NTT Faculty are outside the tenure, non-reappointment, dismissal, and termination policies of the University, although subject to the University promotion policies with review by the Committees on Rank and Tenure.

Currently, NTT grant-funded positions end when the particular grant funds are exhausted. Such faculty employment contracts reflect this.

This policy does not apply to staff or administrative employees. Further, this policy does not apply to tenure-track faculty or tenured faculty regardless of whether or not the faculty position is supported entirely by grant funding. Tenured and tenure-track faculty members are within the University's tenure, non-reappointment, dismissal, termination and promotion policies as set forth in the Handbook for Faculty.
## Policies and Procedures

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### PURPOSE

“Creighton exists for students and learning.” Creighton University, as a Catholic, Jesuit University dedicated to excellence in undergraduate, graduate and professional programs, is committed to an ongoing process of assessment, reflection, evaluation and action that is consistent with the model of Ignatian teaching and learning.

### POLICY

The University is accountable to its students, its other constituents, and the public for evidence of ongoing assessment of student learning in accordance with Creighton University’s mission. The Office for Academic Excellence and Assessment (AEA) is established as the University’s central reporting agency for assessment. The AEA and the University Assessment Committee in conjunction with academic administrators are, therefore, responsible for establishing procedures for (at least) annual assessments (e.g., collecting, collating, reporting, and explicating assessment outcomes, plans, evidence, and actions to improve student learning).

### SCOPE

**Annual Assessment**

Each full-time and part-time faculty member is responsible for assessment of student learning in each course taught and for assisting program faculty in assessment of program learning outcomes as needed. Each course will have clearly stated learning objectives/goals and evaluation of student learning linked to these objectives/goals.

Undergraduate, graduate and professional students are responsible for participation in the approved learning outcome assessment processes of their major, program, college, and the university. Students are expected to complete various assessment measures to the best of their ability.

Each academic unit (college/school, department, and program) and each distinct curricular program (University core, major, certificate, post baccalaureate and graduate, co-curricular), is responsible for assessment of student learning and reporting outcomes annually to their respective Dean(s).

The Deans of each School are responsible for implementing assessment procedures. Deans are responsible to report assessment data on all of their academic programs to the AEA.
DEFINITIONS

**Academic Unit:** An academic unit is a general term and refers to a college or school, a program, and or a department under the Vice Presidents of Academic Affairs and Health Sciences. Each academic unit will have at least one assessment system.

**Assessment Measures:** Assessment measures are the measurement tools that will be used to evaluate student learning. The measure addresses one or more of the performance indicators for a given learning outcome, such as a project, writing sample, research report or clinical assessment form.

**Assessment System:** An assessment system is a detailed description of the process used to implement a cycle of assessment supporting continuous program or curricular improvement. This system consists of specified student learning outcomes, measurement tools/processes for the achievement of each learning outcome, and a structure for use of assessment results for curricular improvement.

**Co-Curricular:** Co-curricular programs are planned activities and formal programs that add to and support the student learning offered by academic support units. Examples include (but are not limited to): Ratio Studiorum, Migrant Journey and other Service-Learning Programs, International Programs, Campus Ministry, Creighton Center for Service and Justice, Cortina Community, and Freshman Leadership Program.

**Course:** A term used to describe a structured and organized learning activity for academic credit or continuing education units.

ADMINISTRATION AND INTERPRETATION

Under the direction of the Vice Presidents of Academic Affairs and Health Sciences, the Office for Academic Excellence and Assessment and the University Assessment Committee are responsible for administering this policy. Questions regarding interpretation of the policy should be addressed to the Associate Vice President for Academic Excellence and Assessment.

AMENDMENTS OR TERMINATION OF THIS POLICY

The University reserves the right to modify, amend, or terminate this policy at any time. This policy is not a contract between Creighton University and its employees.
Policies and Procedures

SECTION: Academic Concerns

CHAPTER: Faculty

POLICY: Misconduct in Scholarly and Scientific Research That is Not Federally Funded

PURPOSE

The purpose of this policy is to establish procedures to thoroughly, timely, objectively, and fairly evaluate, investigate, and respond to allegations of misconduct in scholarly and scientific research.

POLICY

Creighton University fosters an environment that promotes the responsible conduct of scholarly and scientific research. Creighton University shall promptly respond to all allegations or evidence of possible misconduct according to this policy.

SCOPE

This policy applies to faculty and staff of Creighton University engaged in scholarly and scientific research that is not funded in any part by a federal agency.

This policy applies to allegations of misconduct in scholarly and scientific research regardless of the existence or source of funding for the research; provided, however, that this policy does not apply to research misconduct in federally-funded research, research training, or activities related to that research or research training as set forth in University Policy 4.2.2, “Research Misconduct In Federally Funded Research.” Allegations of misconduct that fall within the definition of research misconduct within the scope of Policy 4.2.2 shall be addressed under Policy 4.2.2.

DEFINITIONS

Complainant means any a person who in good faith makes an allegation of misconduct in scholarly or scientific research.

Preponderance of the Evidence means proof by information that, compared with opposing information, leads to the conclusion that the fact at issue is more probably true than not.

Research Record means the record of data or results that embody the facts resulting from scientific or scholarly inquiry, research proposals, laboratory records (both physical and electronic), progress reports, abstracts, theses, oral presentations, internal reports, journal articles, and any documents and materials provided by the Respondent during the course of a misconduct proceeding.
Misconduct means any act that violates the standards of integrity in the conduct of scholarly and scientific research. This includes, but is not limited to, plagiarism (as defined below); fabrication (as defined below); falsification (as defined below); forging academic documents; improprieties of authorship; misrepresentation of qualifications; abusing the confidentiality of information obtained from colleagues or other persons; intentionally or knowingly helping another to commit an act of misconduct, or otherwise facilitating such acts; or other practices that seriously deviate from ethical standards that are commonly accepted within the scientific and scholarly communities for proposing, conducting, or reporting research. It does not include honest error or differences of opinion in the interpretation of data.

Fabrication is making up data or results and recording or reporting them.

Falsification is manipulating research materials, equipment, or processes, or changing or omitting data or results such that the research is not accurately represented in the research record.

Plagiarism is the appropriation of another person's ideas, processes, results, or words without giving appropriate credit.

Respondent means the person against whom an allegation of research misconduct is made, and is the subject of a research misconduct proceeding.

PROCEDURE

1. Allegation of Misconduct
   a. Receipt of an Allegation of Misconduct
      All faculty and staff of Creighton University are required to report known or suspected misconduct. A good faith report of possible misconduct may be made, either verbally or in writing, to any University official, including, but not limited to, the reporting individual’s supervisor, administrator, or Dean, or the Provost. Reports may also be made to the Research Compliance Officer (402-280-2360) or the Research Compliance Hotline (402-280-3200). A report of possible misconduct is not in good faith if it is made with knowing or reckless disregard for information that would negate the allegation. The report of possible misconduct shall be documented (if not already documented by the Complainant) and immediately sent to the Dean(s) of the school/college under which the scholarly or scientific research is conducted and the Research Compliance Officer. If there is more than one school/college involved in the allegation of misconduct, then the Deans of those schools/colleges shall be jointly responsible for determining whether an investigation is warranted, setting the date for the commencement of the investigation, and appointing members to the Ad Hoc Investigative Committee.
In the event the allegation of misconduct involves a Dean or the Dean has a real or apparent conflict of interest in the matter, the determination of whether an investigation is warranted and the completion of other responsibilities set forth for the Dean herein will be completed by the Provost or his/her designee. The Dean(s) shall notify each Respondent of the receipt of an allegation of misconduct.

b. **Review of Allegation by Dean(s)**
   The Dean(s) shall review the allegation of misconduct to determine whether or not an investigation is warranted. The Dean(s) and/or such designees as the Dean(s) determine necessary may review documents and research records and interview individuals as necessary to make this determination. The Dean(s) shall make the determination within 30 days of receiving an allegation of misconduct. An investigation is warranted if there is:
   i. A reasonable basis for concluding that the allegation falls within the definition of misconduct under this policy and involves scholarly or scientific research; and
   ii. Preliminary information gathering and fact-finding indicates that the allegation may have substance.

c. **Appointment of Ad Hoc Investigative Committee**
   If the Dean(s) determine(s) that an investigation is warranted pursuant to paragraph b above, the Dean(s) shall appoint an Ad Hoc Investigative Committee. The Dean(s) shall appoint the Ad Hoc Investigative Committee within 7 calendar days of the determination. The Dean(s) shall make every effort to appoint persons with appropriate knowledge and expertise to the Ad Hoc Investigative Committee and shall ensure that anyone appointed to the Ad Hoc Investigative Committee does not have unresolved personal, professional, or financial conflicts of interest with the Complainant(s), Respondent(s), or witnesses. The Ad Hoc Investigative Committee shall be composed of such persons whom the Dean(s) may choose to designate to serve; provided, however, that at least two members shall be from outside the affected department/division. It is desirable that an appropriate Associate/Assistant Dean and two tenured faculty members of the school/college involved be appointed to the Ad Hoc Investigative Committee, but this is not a formal requirement. Individuals from the department of the Complainant(s) or Respondent(s) should not participate in the Ad Hoc Investigative Committee. The Dean(s) shall designate one of the Ad Hoc Investigative Committee members to act as Chair for the committee. The Ad Hoc Investigative Committee may rely upon consultants with expertise or knowledge in the area of research under investigation.

d. **Notice to Respondent of Allegation**
   The Dean(s) shall notify each Respondent, in writing, prior to the start of any investigation. A copy of the notice(s) shall be sent to the Respondent’s departmental chairperson, administrator, the Provost, the Office of General Counsel, and the Research Compliance Officer.
e. Custody of Research Records
On or before the date on which the Respondent(s) is(are) notified, the Dean(s) shall take all reasonable and practical steps to obtain custody of all known research records and evidence needed to conduct the misconduct proceeding, inventory the records and evidence, and hold them in a secure manner to be available for the misconduct proceedings. In cases in which the research records or evidence encompass scientific instruments shared by a number of users, custody may be limited to copies of the data or evidence on such instruments, so long as those copies are substantially equivalent to the evidentiary value of the instruments.

f. Ensuring Cooperation during the Misconduct Proceeding
Faculty, staff, students, and agents, including Complainant(s), Respondent(s), and witnesses, shall cooperate in the misconduct proceedings, including, but not limited to, being present as requested during the misconduct proceeding and providing relevant and truthful information and research records and evidence.

g. Finding that an Investigation is Not Warranted
The Dean(s) shall sufficiently document the decision not to investigate the allegation of misconduct and shall maintain all records of the allegation and determination in accordance with Section E below. The Dean(s) shall notify the Respondent(s) of the decision not to investigate and a copy of the notice will be sent to the Respondent’s departmental chairperson, administrator, or supervisor, the Provost, the Office of General Counsel, and the Research Compliance Officer.

ii. Investigation
a. Scheduling the Investigation and Required Notices
Should the Dean(s) determine that an investigation is warranted, the Ad Hoc Investigative Committee shall begin the investigation no later than 30 days after the determination. The Ad Hoc Investigative Committee shall complete all aspects of the investigation within 120 days from the date of initiating the investigation, which includes conducting the investigation, preparing the report of findings, and providing the draft report to and obtaining comments from the Respondent(s).

b. Investigation by the Ad Hoc Investigative Committee
i. The Ad Hoc Investigative Committee shall fairly and impartially conduct a thorough review of all research records and evidence and diligently pursue all relevant significant issues and leads (including evidence of additional instances of possible misconduct) in determining whether there was misconduct. The Committee will give the Respondent(s) prompt notice of any new allegations of misconduct that arise during the investigation that will be investigated and were not included within the initial notice of investigation provided by the Dean(s).
## Policies and Procedures

### SECTION:
**Academic Concerns**

### CHAPTER:
**Faculty**

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#### ii. **Respondent's Right to Access Research Records.** Prior to and during the investigation, the Respondent(s) has (have) the right to receive copies of or be given reasonable supervised access to the research records.

#### iii. **Interviews.** The Ad Hoc Investigative Committee shall interview each Respondent, Complainant, and any other available persons who have been identified as having relevant information, including persons identified by the Respondent(s). Interviews shall be recorded or transcribed, with a copy provided to the interviewee for correction. The recording or transcript shall be included in the record of the investigation and be considered a part of the investigative record.

#### c. **Criteria for Finding of Misconduct**

To support a finding of misconduct, the Ad Hoc Investigative Committee must find by a preponderance of the evidence that:

- There was a significant departure from accepted practices of the relevant research and scholarly community; and
- The misconduct was committed intentionally, knowingly, or recklessly.

#### i. **Destruction, Absence of, or Respondent(s)’ Failure to Provide Research Records**

The destruction of, absence of, or Respondent’s failure to provide research records adequately documenting the questioned research is evidence of misconduct in cases in which it is established by a preponderance of the evidence that the Respondent(s) intentionally, knowingly, or recklessly had research records and destroyed them, had the opportunity to maintain the records but did not do so, or maintained the records and failed to produce them in a timely manner, and that the Respondent(s)’ conduct constitutes a significant departure from accepted practices of the relevant research and scholarly community.

#### ii. **Respondent(s)’ Burden of Proof**

Respondent(s) have the burden of proving, by a preponderance of the evidence, any and all affirmative defenses or mitigating factors. The Ad Hoc Investigative Committee shall give due consideration to admissible, credible evidence of honest error or difference of opinion presented by the Respondent(s).

#### d. **Investigation Report.**

i. **Draft Report**

The Ad Hoc Investigative Committee shall prepare a written draft investigation report that shall include the following information:
### Policies and Procedures

**SECTION:** Academic Concerns

**NO.:** 4.2.6.

**CHAPTER:** Faculty

**ISSUED:** 5/15/13

**REV. A**  | **REV. B**  | **REV. C**

**POLICY:** Misconduct in Scholarly and Scientific Research That is Not Federally Funded

| 2. Funding. | A description of the source of funding, if any, including, for example, any grant numbers, grant applications, contracts, and publications listing funding support.
| 3. Institutional Charge. | A description of the specific allegations of misconduct considered during the investigation.
| 4. Policies and Procedures. | Include a copy of this policy.
| 5. Research Records and Evidence. | Identity and summary of research records and evidence reviewed, as well as records and evidence taken into custody but not reviewed.
| 6. Statement of Findings. | A finding of whether misconduct did or did not occur for each separate allegation of misconduct considered during the investigation. For each finding of misconduct:
| 1. | identify the form of misconduct;
| 2. | identify whether it was intentional, knowing, or in reckless disregard;
| 3. | summarize the facts and analysis that support the conclusion;
| 4. | consider the merits of any reasonable explanation by the Respondent(s);
| 5. | identify the specific funding support;
| 6. | identify whether any publications need correction or retraction;
| 7. | identify the person(s) responsible for the misconduct; and
| 8. | identify any other corrective action recommended.
| 7. Other Support. | Listing of any other funding support or known applications or proposals for support that the Respondent(s) have pending with any funding entity.

#### ii. Opportunity for Comment

1. **Respondent(s)**
   - The Respondent(s) shall be given a copy of the draft investigation report, along with a copy of (or supervised access to) the records and evidence on which the report is based. The Respondent(s) shall have 30 days from date of receipt of the report to submit any comments to the Ad Hoc Investigative Committee.

2. **Complainant(s)**
   - At the discretion of the Ad Hoc Investigative Committee, the Complainants may be given a copy of the draft investigation report or relevant portions of that report. The Complainant(s) shall have 30 days from the date of receipt of the report to submit any comments to the Ad Hoc Investigative Committee.
iii. Final Report
The Ad Hoc Investigative Committee shall issue its final report, which shall contain all of the information outlined in paragraph 6.a above, any written comments received from the Respondent(s) and/or Complainant(s) within the time period set forth in paragraph ii.1 above, and the Ad Hoc Investigative Committee’s consideration of and response to any comments received from the Respondent(s) or Complainant(s). A copy of the final report shall be given to the Respondent(s), redacting identities of any research subjects. A copy of the final report shall also be given to the Provost, Dean, administrator, or supervisor; the Office of General Counsel; and the Research Compliance Officer, redacting the identity of any research subjects. At the discretion of the Ad Hoc Investigative Committee, the Committee may provide a copy of the final report to the Complainant(s).

3. Institutional Actions
   a. Finding of Misconduct
      If the alleged misconduct is substantiated by thorough investigation of the Ad Hoc Investigative Committee, the recommendations of the Ad Hoc Investigative Committee contained in the final report may be implemented and the following actions, if not already recommended by the Ad Hoc Investigative Committee in its final report, may be taken:
      i. Restitution of funding as appropriate or if required by the funding entity or contract.
      ii. Withdrawal of abstracts and papers emanating from the questioned research, and notification of editors of journals and publications that published previous abstracts and papers concerning the research, if the Ad Hoc Investigative Committee concludes that substantiated misconduct makes such abstracts and papers of questionable validity. The Dean is authorized to request/direct such actions if the researcher(s) involved fail(s) to do so within a reasonable time after the Dean directs such actions.
      iii. Appropriate action (including interim administrative actions) to terminate or alter the status of Respondent(s) whose misconduct is substantiated, or to impose other sanctions deemed appropriate under the circumstances.
      iv. The Dean, the Provost, and the President of the University shall consider, in consultation with the Office of General Counsel, release of information about the misconduct to the public and/or press.

   b. No Findings of Research Misconduct
      If the Ad Hoc Investigative Committee finds that there was no misconduct, efforts shall be undertaken as and if necessary to restore the position and reputation of the Respondent(s).
   a. Confidentiality
      i. Identity of Participants in Misconduct Proceedings
         Disclosure of the identity of Respondents, Complainants, and witnesses involved in
         misconduct proceedings is limited to those who need to know, to the extent possible
         consistent with a thorough, competent, objective, and fair misconduct proceeding, and as
         allowed or required by law.
      ii. Records and Evidence
         Except as otherwise required by law, confidentiality of all records and evidence from which
         research subjects might be identified shall be maintained. Disclosure of such information is
         limited to those who have a need to know to carry out a misconduct proceeding.
   b. Safeguards
      The rights, privacy, positions, and reputations of all parties involved in the misconduct proceedings
      shall be protected. No one shall retaliate against any Complainant, witness, or committee member
      who, in good faith, participates in a misconduct proceeding.
      iii. All reasonable and practical efforts shall be taken to restore the position and reputation of
           Respondents where there is no finding of misconduct.
      iv. All reasonable and practical efforts shall be taken to restore the position and reputation of
           any Complainant, witness, or committee member and to counter potential or actual
           retaliation against these individuals.
      v. Disciplinary action will be taken, in accordance with University policy, against anyone who
         fails to act in good faith in either bringing an allegation of misconduct, cooperating during
         the misconduct proceedings (i.e., providing evidence) or serving as a member of the Ad Hoc
         Investigative Committee. An allegation or cooperation with a misconduct proceeding is not
         in good faith if made with knowing or reckless disregard for information that would negate
         the allegation or testimony. A committee member does not act in good faith if his/her acts or
         omissions on the committee are dishonest or influenced by personal, professional, or
         financial conflicts of interest with those involved in the misconduct proceeding.
   c. Notice to Funding Entities
      At any time during the misconduct proceeding, the entity funding the activity shall be notified as
      required by the funding agreement. Prior to the commencement of any investigation, the Dean(s) of
      the school/college conducting the research shall notify the Research Compliance Officer, who shall
      notify the funding entities after consultation with the Office of General Counsel in cases in which
      such notification is determined required or necessary.
d. Role of the Office of General Counsel
The Office of General Counsel is available to render advice to the Dean(s), the Research Compliance Officer, or the Ad Hoc Investigative Committee at any step in the misconduct proceedings. Individuals serving in any of these capacities are encouraged to seek legal guidance regarding any procedural question, particularly in connection with the preparation of written reports of actions taken, or before any action is taken with respect to any person believed to have made an accusation of misconduct in bad faith. Any contact or inquiry to the University from a lawyer outside the University, including contacts and inquiries emanating from legal representatives of any Respondent, funding entity, or federal, state, or local agency, must be referred to the Office of General Counsel.

5. Maintenance of Research Records and Evidence Related to Misconduct Proceedings
The following records of misconduct proceedings shall be maintained for 3 years after completion of the misconduct proceeding or per the funding agency or contract.

- The records secured for the investigation, except to the extent it is subsequently determined that those records are not relevant to the investigation or that the records duplicate other records that are being retained;
- The documentation of the determination of irrelevant or duplicate records; and
- The investigation report and all records (other than drafts of the report) in support of the investigation report, including the recordings or transcriptions of each interview conducted during the investigation stage.

ADMINISTRATION
The Dean(s) of the affected school/college and the Research Compliance Officer are responsible for administering this policy when there is an allegation of misconduct. The Dean(s) of the affected school/college shall report any final action taken under this policy to the Provost, the Office of General Counsel, and the Research Compliance Officer.

AMENDMENTS OR TERMINATION OF THIS POLICY
Creighton University reserves the right to modify, amend, or terminate this policy at any time.
**Policies and Procedures**

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**PURPOSE**

The University's policy on confidentiality of student records exists to comply with the Family Educational Rights and Privacy Act of 1974 in maintaining students' rights to confidentiality of University-held records of their academic careers.

**POLICY**

In compliance with the "Family Educational Rights and Privacy Act of 1974 As Amended," Creighton maintains the confidentiality of student records. Specific guidelines for implementing the policy under the Act are published for the information of all students and other members of the University community in a separate booklet entitled "Student Records Policy." Copies are available in the office of each Academic Dean and the University Registrar.

**SCOPE**

This policy applies to all University employees who have access to, or knowledge of the contents of student academic and personal records.

**PROCEDURES**

Supervisors of employees who work with or have access to student records should be sure that those employees are informed of and understand this policy. Communication of this policy to all new employees should take place during departmental orientation or initial training periods.

Additionally, supervisors in areas where student records are housed should make sure that procedures are developed to ensure the confidentiality and security of those records, should communicate these procedures to employees, and hold them accountable for following the security/confidentiality procedures.

**ADMINISTRATION AND INTERPRETATIONS**

Questions regarding this policy may be addressed to Human Resources, to Academic Deans and their staff, or to the University Registrar.
AMENDMENTS OR TERMINATION OF THIS POLICY

Creighton University reserves the right to modify, amend, or terminate this policy at any time, especially to comply with changes in federal law.

RELATED ISSUES

The University does not give information about staff members', students', or patients' addresses, telephone numbers, or other confidential information to anyone outside the University; such information is disseminated internally only on a strict "need to know" basis, except for such information published in University directories.
Creighton University, a Jesuit University, is convinced that the hope of humanity is the ability of men and women to seek the truths and values essential to human life. We believe that the deepest purpose of each man and woman is to create, enrich, and share life through love and reverence in the human community. We believe therefore that to enter into a sexual relationship outside the bond of enduring marriage is morally harmful. The University will not provide services through Student Health which could be construed as encouragement or tacit support for any such actions. The University must however recognize the privacy of the individual's conscience, and does not therefore make moral judgment concerning personal lives. We cannot and do not police the domain of private conscience.

Contraceptives for the purpose of birth control are not available to Creighton University students through Student Health.
PURPOSE

To advise Creighton University's students of the steps that should be taken when the student is exposed to potentially infectious blood or body fluid during their course of study at Creighton.

DEFINITIONS

Exposure is defined as, but not limited to, percutaneous (i.e., through the skin) injury or contact of mucous membranes, skin, or eyes with blood, tissues, or other body fluids. Skin exposure occurs when exposed skin is chapped, abraded, or afflicted with dermatitis (i.e., inflammation of the skin) or the contact is prolonged or involving an extensive area.

Significant exposure to blood or other body fluid is defined as specific eye, mouth or other mucous membrane, nonintact skin or parenteral (i.e., injection, needle stick) contact with blood or other materials known to transmit infectious diseases.

POLICY

1. Education of Students. Each School/Department is responsible for educating students who may be exposed to blood and/or body fluids as part of their course of study, on the universal precautions that should be followed to reduce the risk of exposure to potentially infectious blood and/or body fluids and the contents of this policy.

2. Response to Exposure. In case of suspected exposure to potentially infectious blood or body fluids in the academic or clinical setting, the student should:

   STOP current activity and should seek evaluation and treatment within one hour of exposure.
   CLEANSE any wound with soap and water. Flush eyes with water after any splash exposure.
   REPORT to your supervisor/faculty and the appropriate facility/institutional supervisor.

   In the clinical setting, appropriate institutional reporting is necessary so informed consent may be obtained and appropriate diagnostic testing of the source patient and student may be performed. Any diagnostic testing performed on the student and/or source patient should include HIV, Hepatitis B, and Hepatitis C.
Policies and Procedures

SECTION:  
Academic Concerns

CHAPTER:  
Students

POLICY:  
Student Exposure to Infectious Disease

3. Report of Incident. In all instances of exposure to potentially infectious blood or body fluid, the student should:

   A. Notify Student Health Services. Contact Student Health Services (280-2735) within 24-48 hours of the incident.

   B. Incident Report Form. Incidents that occur at Creighton clinics should be reported using the University Incident Report Form (HR-24). Incidents occurring at other facilities should be reported using the facility's incident report form and the University HR-24 Form. Fax the completed HR-24 incident report form to Student Health Services (402-280-1859).

4. Procedure for Initiating Evaluation and Treatment

   A. Exposures at Creighton University Medical Center (Saint Joseph Hospital, On-campus Creighton Clinics and their laboratories, and the Dental School).

      During regular business hours (7:30 a.m. to 4:00 p.m.) students should go directly to Employee Health Services, located in Human Resources, Room 2231 (449-4467). On weekends and holidays (7:00 a.m. to 3:00 p.m.) students should go directly to the Emergency Department. During all evening and night shifts page the House Nursing Supervisor on in-house pager 22-0422.

   B. Exposures at Other Hospitals/Institutions/Non-Creighton Clinics.

      Students should be advised to contact the Nursing/House Supervisor or the Health Sciences School Office of Student Affairs and follow their institutional procedures for exposure.

   C. Exposures at Creighton University Medical Center (Off-campus Clinics and Laboratories).

      Students should immediately report the incident to their supervisor/faculty. Alternatively, the student may go to Employee Health Services (Creighton University Medical Center - Saint Joseph Hospital), located at Human Resources, Room 2231 (449-4467).
### Policies and Procedures

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#### D. Exposures at Other Locations (Non-Hospital; Out of USA)

The sponsoring School at the University shall be responsible for identifying a program contact person to arrange for appropriate medical care and intervention for all non-hospital programs and programs outside the USA such as ILAC in which a University student is participating.

#### E. Notification of Student Health or Primary Care Provider

In all cases of exposure in the Omaha area, the student should make an appointment with Student Health (402-280-2735) or their Primary Care Provider within 24-48 hours after the exposure. Students outside the Omaha area should contact Student Health Services (402-280-2735) or their Primary Care Provider within 24-48 hours.

#### F. Student Refusal of Evaluation and Treatment

The student's supervisor/faculty shall advise the student of the risks/benefits of evaluation and diagnostic testing. If the student refuses to seek evaluation and diagnostic testing, the student's refusal of evaluation and diagnostic testing shall be noted on the institutional incident report form and signed by the student.

### 5. Student Request for Source Testing

In Nebraska when an individual experiences a significant exposure to the blood or body fluid of a patient, the individual has the right to request that the source patient be asked to consent to diagnostic testing for the presence or absence of infectious disease (i.e., HIV, Hepatitis B, Hepatitis C). Students should be advised that any requests must be made to the appropriate institution. Creighton University shall comply with the consent requirements set forth by Nebraska statute, Neb. Rev. Statute 71-514.03 for its outpatients that are the source of the exposure.

### 6. Payment for Evaluation and Treatment

Creighton health sciences students are required to have both inpatient and outpatient health insurance which covers accidents and illnesses. All charges for evaluation and treatment shall be submitted to the student's health insurance company for payment. Prescribed initial diagnostic testing and initial prophylactic treatment which is not paid by the student's insurer will be paid for by the School until the source test results are received, but for no longer than five (5) business days. This includes payment for any student co-pays and deductibles incurred during the first five days after initial diagnostic testing and initiation of prophylactic treatment. All other evaluation and treatment services and/or prophylactic treatments ordered are the responsibility of the student or his/her insurer.
Policies and Procedures

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NO. 4.3.3.

CHAPTER: Students

ISSUED: 11/90
REV. A 11/93
REV. B 12/10/03

POLICY: Student Exposure to Infectious Disease

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ADMINISTRATION

This policy shall be administered by the Deans of each School. Questions regarding this policy should be directed to the Dean of the School or his/her designee.

AMENDMENTS OR TERMINATION OF POLICY

Creighton University reserves the right to modify, amend or terminate this policy at any time.
Policies and Procedures

SECTION:  
Academic Concerns

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Students

POLICY:  Preventing Transmission of Bloodborne Pathogens from Students to Patients

PURPOSE

To prevent the transmission of bloodborne pathogens from students during the course of their professional training at Creighton University.

POLICY

Creighton University follows public health recommendations of the Centers for Disease Control (CDC) and other public health agencies as part of implementing this policy to prevent transmission of bloodborne pathogens from students to patients.

SCOPE

This policy applies to any student who may perform exposure-prone procedures during the course of their studies at Creighton University.

DEFINITIONS

"Bloodborne pathogens" means, for purposes of this policy, human immunodeficiency virus (HIV), hepatitis B virus (HBV), and hepatitis C virus (HCV).

"Exposure-prone procedures" are distinct from invasive procedures. Characteristics of exposure-prone procedures include digital palpation of a needle tip in a body cavity or the simultaneous presence of the health care worker's fingers and a needle or other sharp instrument or object in a poorly visualized or highly confined anatomic site. Performance of exposure-prone procedures presents a recognized risk of percutaneous injury to the health care worker and if such an injury occurs, the health care worker's blood is likely to contact the patient's body cavity, subcutaneous tissues, and/or mucous membranes.

PROCEDURE

A. Responsibility of Schools/Departments.

Schools/Departments whose students may perform exposure-prone procedures as a part of their course of study shall:

- Educate their students about this policy and about the risk of bloodborne pathogen transmission through exposure-prone procedures; and

- Provide students infected with bloodborne pathogens a contact within the School/Department to request guidance.
B. Responsibility of Students with Bloodborne Pathogens

Students who are infected with bloodborne pathogens and who will perform exposure-prone procedures shall:

- Notify their School/Department contact of their status and seek counsel from an expert review panel before performing any exposure-prone procedures; and

- Not perform any exposure-prone procedures until they have obtained guidance from an expert review panel and been advised under what circumstances, if any, they may perform these procedures.

C. Expert Review Panel

1. Convening an Expert Review Panel. Upon receipt of information that a student with bloodborne pathogens may perform exposure-prone procedures, the Dean of the School shall convene an expert review panel to advise on the precautions and/or limitations, if any, that should be implemented.

2. Composition. The expert review panel shall include experts who represent a balanced perspective and shall include at least one physician with subspecialty training in infectious disease.

3. Confidentiality. Members of the expert review panel shall maintain the confidentiality of any information obtained through the review process.

4. Responsibilities. The expert review panel shall provide advice based on up-to-date public health recommendations, which currently includes the Centers for Disease Control and Prevention, Recommendations for Preventing Transmission of Human Immunodeficiency Virus and Hepatitis B Virus to Patients During Exposure-Prone Invasive Procedures. MMWR Morbidity and Mortality Weekly Report Recommendations and Reports 1991 (July 12); 40(RR08):1-9. 
http://www.cdc.gov/mmwr/preview/mmwrhtml/00014845.htm
AMENDMENTS OR TERMINATION OF THIS POLICY

Creighton University reserves the right to modify, amend or terminate this policy at any time.
UNIVERSITY STATUTES

See the University Statutes on-line at:
http://www.creighton.edu/office-of-the-president/organization
FACULTY HANDBOOK

See the Faculty Handbook on-line at:
http://www.creighton.edu/office-of-the-president/organization
See the *Employee Handbook* on-line at (available in English and Spanish):
http://www2.creighton.edu/hr/resources/handbooken/welcome/index.php
STUDENT HANDBOOK

See the Student Handbook on-line at:
http://www.creighton.edu/students/aboutstudentlife/studenthandbook/index.php
AFFIRMATIVE ACTION

See the Affirmative Action website at:
http://www.creighton.edu/about/affirmativeaction/
BUDGET OFFICE

See the Budget Office website at:
http://www.creighton.edu/finance/budget/budgetoffice/index.php
ACCOUNTING/SHARED SERVICES
POLICIES AND PROCEDURES

See the Accounting Services on-line at:
http://www.creighton.edu/finance/shareservices/home/index.php
See the Graphic Standards Manual on-line at:
http://logo.creighton.edu/
PURCHASING DEPARTMENT

See the Purchasing Policies on-line at:
http://www2.creighton.edu/admin/purchasing/policies/index.php
UNIVERSITY’S ORGANIZATIONAL CHART

See the Organizational Chart on-line at:
http://www.creighton.edu/office-of-the-president/organization