



**Checklist for University of Wisconsin-Madison Business Associates**

(For use when members of UW-Madison serve as Business Associates for a Covered Entity)

Note: This Checklist must be completed before a Business Associate Agreement will be signed by a Board of Regents authorized signatory, for the provision of Business Associate services by a member or agent of UW-Madison. Attach this completed Checklist to the Business Associate Agreement when routed for signature.

Name of Business Associate: \_\_\_\_\_

Business Associate Information: Job Title \_\_\_\_\_

Department or Work Unit \_\_\_\_\_

Office location \_\_\_\_\_

Telephone number \_\_\_\_\_

E-mail address \_\_\_\_\_

Name of Covered Entity: \_\_\_\_\_

Describe the nature of the Business Associate Services Involved (this should align with the description of services in the Business Associate Agreement): \_\_\_\_\_

\_\_\_\_\_

As the Business Associate, I certify that I, and individuals performing Business Associate services at my direction (initial each line):

\_\_\_\_\_ Reviewed the Business Associate Agreement and understand my responsibilities with respect to use and/or disclosure of the involved Covered Entity’s protected health information (“PHI”) and with respect to safeguarding of the PHI from unapproved uses or disclosures; and

\_\_\_\_\_ Reviewed the Business Associate Training available at <https://compliance.wisc.edu/hipaa/business-associates/> (must be completed at least once per calendar year for as long as you are a Business Associate).

I acknowledge and agree that I will comply with the University of Wisconsin-Madison’s policies and procedures as they relate to HIPAA privacy and security of PHI, and will abide by the terms of the Business Associate Agreement under which I provide Business Associate services. I understand that I may be subject to discipline, up to and including termination, for violations of HIPAA regulations and/or University of Wisconsin-Madison policies and procedures relating to HIPAA.

\_\_\_\_\_  
Signature of Business Associate

\_\_\_\_\_  
Date

*This section must be completed by UW-Madison’s Chief Information Security Officer or the HIPAA Security Officer.*

I verify that a member of the Cybersecurity team has instructed the Business Associate named above regarding the security of PHI with which it will interact in connection with its provision of Business Associate services

\_\_\_\_\_  
Signature of UW-Madison CISO or HIPAA Security Officer

\_\_\_\_\_  
Date