KENDALL REGIONAL Medical Center

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PROGRAM PARTICIPANT (STUDENT PARTICIPANT OR FACULTY PARTICIPANT) SIGNS:

EXHIBIT A

STATEMENT OF RESPONSIBILITY

For and in consideration of the benefit provided the undersigned in the form of experience in a clinical setting at _____ ("Hospital"), the undersigned and his/her heirs, successors and/or assigns do hereby covenant and agree to assume all risks and be solely responsible for any injury or loss sustained by the undersigned while participating in the Program operated by _____ ("School") at Hospital unless such injury or loss arises solely out of Hospital's gross negligence or willful misconduct.

_____

PRINT NAME

_____ _____

Signature Date

_____ _____

Parent or Legal Guardian if Program Participant is under 18/Print Name Date

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PROGRAM PARTICIPANT (STUDENT PARTICIPANT OR FACULTY PARTICIPANT) SIGNS:

EXHIBIT B

Confidentiality and Security Agreement

I understand that the facility or business entity (the "Company") for which I work, volunteer or provide services manages health information as part of its mission to treat patients. Further, I understand that the Company has a legal and ethical responsibility to safeguard the privacy of all patients and to protect the confidentiality of their patients' health information. Additionally, the Company must assure the confidentiality of its human resources, payroll, fiscal, research, internal reporting, strategic planning information, or any information that contains Social Security numbers, health insurance claim numbers, passwords, PINs, encryption keys, credit card or other financial account numbers (collectively, with patient identifiable health information, "Confidential Information").

In the course of my employment/assignment at the Company, I understand that I may come into the possession of this type of Confidential Information. I will access and use this information only when it is necessary to perform my job related duties in accordance with the Company's Privacy and Security Policies, which are available on the Company intranet (on the Security Page) and the Internet (under Ethics & Compliance). I further understand that I must sign and comply with this Agreement in order to obtain authorization for access to Confidential Information or Company systems.

General Rules

1. I will act in the best interest of the Company and in accordance with its Code of Conduct at all times during my relationship with the Company.
2. I understand that I should have no expectation of privacy when using Company information systems. The Company may log, access, review, and otherwise utilize information stored on or passing through its systems, including email, in order to manage systems and enforce security.
3. I understand that violation of this Agreement may result in disciplinary action, up to and including termination of employment, suspension, and loss of privileges, and/or termination of authorization to work within the Company, in accordance with the Company's policies.

Protecting Confidential Information

1. I understand that any Confidential Information, regardless of medium (paper, verbal, electronic, image or any other), is not to be disclosed or discussed with anyone outside those supervising, sponsoring or directly related to the learning activity.
2. I will not disclose or discuss any Confidential Information with others, including friends or family, who do not have a need to know it. I will not take media or documents containing Confidential Information home with me unless specifically authorized to do so as part of my job. Case presentation material will be used in accordance with Facility policies.
3. I will not publish or disclose any Confidential Information to others using personal email, or to any Internet sites, or through Internet blogs or sites such as Facebook or Twitter. I will only use such communication methods when explicitly authorized to do so in support of Company business and within the permitted uses of Confidential Information as governed by regulations such as HIPAA.
4. I will not in any way divulge, copy, release, sell, loan, alter, or destroy any Confidential Information except as properly authorized. I will only reuse or destroy media in accordance with Company Information Security Standards and Company record retention policy.

5. In the course of treating patients, I may need to orally communicate health information to or about patients. While I understand that my first priority is treating patients, I will take reasonable safeguards to protect conversations from unauthorized listeners. Whether at the School or at the Facility, such safeguards include, but are not limited to: lowering my voice or using private rooms or areas (not hallways, cafeterias or elevators) where available.
6. I will not make any unauthorized transmissions, inquiries, modifications, or purgings of Confidential Information. I will not access data on patients for whom I have no responsibilities or a need-to-know the content of the PHI concerning those patients.
7. I will not transmit Confidential Information outside the Company network unless I am specifically authorized to do so as part of my job responsibilities. If I do transmit Confidential Information outside of the Company using email or other electronic communication methods, I will ensure that the Information is encrypted according to Company Information Security Standards.

Following Appropriate Access

1. I will only access or use systems or devices I am officially authorized to access, and will not demonstrate the operation or function of systems or devices to unauthorized individuals.
2. I will only access software systems to review patient records or Company information when I have a business need to know, as well as any necessary consent. By accessing a patient's record or Company information, I am affirmatively representing to the Company at the time of each access that I have the requisite business need to know and appropriate consent, and the Company may rely on that representation in granting such access to me.

Using Portable Devices and Removable Media

1. I will not copy or store Confidential Information on removable media or portable devices such as laptops, personal digital assistants (PDAs), cell phones, CDs, thumb drives, external hard drives, etc., unless specifically required to do so by my job. If I do copy or store Confidential Information on removable media, I will encrypt the information while it is on the media according to Company Information Security Standards
2. I understand that any mobile device (Smart phone, PDA, etc.) that synchronizes company data (*e.g.*, Company email) may contain Confidential Information and as a result, must be protected. Because of this, I understand and agree that the Company has the right to:
    a. Require the use of only encryption capable devices.
    b. Prohibit data synchronization to devices that are not encryption capable or do not support the required security controls.
    c. Implement encryption and apply other necessary security controls (such as an access PIN and automatic locking) on any mobile device that synchronizes company data regardless of it being a Company or personally owned device.
    d. Remotely "wipe" any synchronized device that: has been lost, stolen or belongs to a terminated employee or affiliated partner.
    e. Restrict access to any mobile application that poses a security risk to the Company network.

Doing My Part – Personal Security

1. I understand that I will be assigned a unique identifier (*e.g.*, 3-4 User ID) to track my access and use of Confidential Information and that the identifier is associated with my personal data provided as part of the initial and/or periodic credentialing and/or employment verification processes.
2. I will:
    a. Use only my officially assigned User-ID and password (and/or token (*e.g.*, SecurID card)).
    b. Use only approved licensed software.
    c. Use a device with virus protection software.
3. I will never:
    a. Disclose passwords, PINs, or access codes.

b. Use tools or techniques to break/exploit security measures.
c. Connect unauthorized systems or devices to the Company network.

4. I will practice good workstation security measures such as locking up diskettes when not in use, using screen savers with activated passwords, positioning screens away from public view.
5. I will immediately notify my manager, Facility Information Security Official (FISO), Director of Information Security Operations (DISO), or Facility or Corporate Client Support Services (CSS) help desk if:
    a. my password has been seen, disclosed, or otherwise compromised;
    b. media with Confidential Information stored on it has been lost or stolen;
    c. I suspect a virus infection on any system;
    d. I am aware of any activity that violates this agreement, privacy and security policies; or
    e. I am aware of any other incident that could possibly have any adverse impact on Confidential Information or Company systems.

Upon Termination

1. I agree that my obligations under this Agreement will continue after termination of my employment, expiration of my contract, or my relationship ceases with the Company.
2. Upon termination, I will immediately return any documents or media containing Confidential Information to the Company.
3. I understand that I have no right to any ownership interest in any Confidential Information accessed or created by me during and in the scope of my relationship with the Company.

By signing this document, I acknowledge that I have read this Agreement and I agree to comply with all the terms and conditions stated above.

Employee/Consultant/Vendor Signature	Facility Name and COID	Date
Employee/Consultant/Vendor Printed Name	Business Entity Name	

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PROGRAM COORDINATOR COMPLETES:

EXHIBIT C

Attestation of Satisfactory Background Investigation and Drug and Alcohol Report

On behalf of _____ [Name of Volunteer Organization, School, Contract Services Entity, or Staffing Agency], I acknowledge and attest to _____ [Name of facility] ("Hospital") that we own, and have in our possession, a background investigation report on the individual identified below. Such background investigation and drug and alcohol report is satisfactory in that it:

____ does not reveal any criminal activity;
____ does not reveal ineligibility for rehire with any former employer or otherwise indicate poor performance;
____ confirms the individual is not on either the GSA or OIG exclusion lists;
____ confirms the individual is not listed as a violent sexual offender;
____ confirms this individual is not on the U.S. Treasury Department's Office of Foreign Assets Control list of Specially Designation Nationals;
____ no other aspect of the investigation required by Employer reveals information of concern
____ does not reveal the inappropriate use of drugs or alcohol.

I further attest there are no prior or pending investigations, reviews, sanctions or peer review proceedings; or limitations of any licensure, certification or registration.

This attestation is provided in lieu of providing a copy of the background investigation and/or the drug and alcohol report.

Identified Individual Subject to the Background Investigation:

_____
Name

_____
Address

_____
Date of Birth

_____
Last 4 digits of Social Security Number

I also acknowledge and agree to an annual compliance audit by Hospital of five percent (5%) or a minimum of thirty (30) such background investigation files as authorized by the subjects under the Fair Credit ReportingAct (FCRA)

_____
Printed Name

_____
Signature

Name of Organization _____**Date:**_____

KENDALL REGIONAL Medical Center

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PROGRAM PARTICIPANT (STUDENT PARTICIPANT OR FACULTY PARTICIPANT) COMPLETES:

EXHIBIT D

Outcome of Background Results Acknowledgement

I acknowledge that Hospital may make the determination, regarding specific background information, that would disqualify me from participating in the Program at the Hospital's healthcare facility, and that School is not involved in, and has no control over, that determination. I understand that if I am disqualified from participating in the clinical program as a result of the background screening, I may not be permitted to continue in the Medical Center Campus program in which I am enrolled.

I hereby sign this form voluntarily with the understanding that a background screening is a prerequisite to clinical placement in the Program.

Name:_____
Date of Birth:_____
Student Number:_____ (if applicable)

I have worked, resided or been a student in a State other than Florida, or a country other than the United States, during the past 24 months:

Yes_____No_____

If Yes, name of State or Country:_____

_____Date:_____
SIGNATURE

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COORDINATOR COMPLETES (initial next to items listed):

EXHIBIT E

School Ownership of Documents Acknowledgement

On behalf of _____ ("School"), I acknowledge and attest to Hospital that we own, and have in our possession, satisfactory results of the following information:

If Student or Faculty:

Medical Clearance statement including:

_____Negative PPD/Chest X-ray (performed within one year)

_____Immunizations (MMR, Varicella)

_____Hepatitis B vaccine

_____Influenza vaccine (If declined, include signed Declination form)

If Student:

_____Statement from Physician that student is capable of participating in Program

If Faculty:

_____Verifies professional license

_____Confirms certification and designations

_____Confirms professional disciplinary action search

_____Confirms Department of Motor Vehicle driving history, based on responsibilities

_____Confirms Consumer Credit Report, based on responsibilities

_____Confirms current BLS (CPR) certification

If Faculty or Student:

_____I further attest there are no prior or pending investigations, reviews, sanctions or peer review proceedings or limitations of licensure, certification or registration.

_____I further attest that the individual is legally permitted to work in the United States.

KENDALL REGIONAL Medical Center
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COORDINATOR COMPLETES

EXHIBIT E (continued)

Identified Individual subject to the background investigation:

_____ _____ _____
Name Phone email address

_____
Address (Street, city, state, zip code)

_____ _____
Date of Birth **Last 4 digits of Social Security Number**

Type of Education Program/Curriculum:_____
(nursing, D.O, physical therapy, etc.)

Semester Objectives attached? o Yes o No

If No, reason:_____

_____

First Day of Rotation:_____**Last Day** of Rotation:_____

Clinical Day(s): Please check all that apply:
oMonday oTuesday oWednesday oThursday oFriday oSaturday oSunday

Shift:_____

Instructor Name:_____

Assigned **Unit, Department, Doctor/Clinician:**_____

I also acknowledge and agree to an annual compliance audit by Hospital of five percent (5%) ora minimum of thirty (30) such background investigations.

_____ _____
Signature/Title Printed Name/Title

_____ _____
School Date

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EXHIBIT F

Orientation Attestation

Name of Student: _____

o Student will attend Day 1, Orientation at Kendall Regional Medical Center before beginning his/her rotation. (Scheduled by the Education Department at KRMC)

Scheduled date for orientation:_____