ATTACHMENT A

STUDENT PARTICIPATION AGREEMENT AND WAIVER

I, _____, am a student at RC Health Services ("Sponsoring Institution") during which I will be participating in a clinical rotation at CHI St. Joseph Health Regional Hospital ("Hospital"). As a condition of participation, I agree to the following terms and conditions:

1. I agree to abide by all hospital policies and procedures at all times while I am at the Hospital participating in the clinical rotation. I further agree to undergo any required training regarding OSHA training on occupational exposure, universal precautions and infection control; body mechanics; electrical and fire/disaster safety; HIPAA compliance and any other training required by Hospital.

2. I do not have a medical condition that may cause injury or illness to myself, to Hospital employees, or to the patients that I will be in contact with, that I have not disclosed to Hospital's Coordinator. I agree to inform Hospital's Coordinator if I develop any such condition or disease during the course of my participation in the clinical rotation. Including, but not limited to, runny nose, fever, rash, etc. I agree to undergo a physical health exam before the clinical education rotation begins to include immunizations and tests, per CDC guidelines for: (i) complete Hepatitis B vaccination; (ii) TB Screening (including chest x-ray, as applicable); (iii) MMR vaccination(s) or positives titers; (iv) varicella vaccination or varicella titer. I further agree to provide a physician's statement regarding the status of my health to Hospital upon request.

3. I agree that I will not be an employee of the Hospital and that I will not be entitled to any of the wages and benefits of employment at the Hospital, including workers' compensation.

4. I understand that there is a risk of transmission of disease from a patient to myself and that such transmission can occur without any fault or negligence on the part of the Hospital or its employees. I have health insurance that will provide benefits in the event that I contract or develop a medical condition or disease during the clinical rotation.

5. I agree to sign a confidentiality agreement and to maintain the confidentiality of any patient information I have access to or learn while I am participating in the clinical rotation at the Hospital.

6. I agree to respond promptly to all directions given to me by medical and nursing staff, including any requests to leave any area, immediately.

7. I understand that my failure to comply with the terms and conditions of the Participation Agreement will cause an immediate termination of any right or expectation that I may have to participate in the clinical rotation at the Hospital pursuant to this Participation Agreement.

8. I save and hold harmless Hospital and/or any subsidiaries, affiliates, officers, contractors, providers, directors, employees, servants and agents or other third parties designated by these entities or individuals from any liability for any personal injury or potential exposure or property damage which may occur as a result of my presence in the Hospital.

9. I agree to ensure that any report or communication involving this training shall contain only de-identified information as defined by 45 CFR 160.514(b)(2)(i) and shall not contain any of the following information:

1. Names;
2. All geographic subdivisions smaller than a State, including street address, city, county, precinct, zip code, and their equivalent geo codes, except for the initial three digits of a zip code if, according to the current publicly available data from the Bureau of the Census: (1) The geographic unit formed by combining all zip codes with the same three initial digits contains more than 20,000 people; and (2) The initial three digits of a zip code for all such geographic units containing 20,000 or fewer people is changed to 000.
3. All elements of dates (except year) for dates directly related to an individual, including birth date, admission date, discharge date, date of death; and all ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of 90 or older;
4. Telephone numbers;
5. Fax numbers;
6. Electronic mail addresses;
7. Social Security numbers;
8. Medical record numbers;
9. Health plan beneficiary numbers;
10. Account numbers;
11. Certificate/license numbers;
12. Vehicle identifiers and serial numbers, including license plate numbers;
13. Device identifiers and serial numbers;
14. Web Universal Resource Locators (URLs).

10. I have also received a copy of the *Ethical and Religious Directives* (as such term is defined in Additional Provisions, Attachment C attached hereto) and agree to comply with the terms of these documents.

11. If required by state law or Hospital policy, I agree to consent to undergo criminal background screening and drug and alcohol testing prior to being allowed to begin the clinical rotation at the Hospital.

12. I certify that I am not and at no time have been excluded from participation in any federally funded health care program, including Medicare and Medicaid and further agree to immediately notify Hospital of any threatened, proposed, or actual exclusion.

13. If insurance coverage for me is not provided by the Sponsoring Institution, I agree to obtain professional liability coverage in the amount of one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) annual aggregate from an insurance carrier reasonably acceptable to Hospital, but at a minimum with a rating of B++ or higher. Insurance shall cover all acts, omissions or commissions by me (the Student). I further agree to provide Hospital with a certificate evidencing such insurance upon request.

14. I understand that the Hospital shall provide emergency medical treatment consistent with Hospital's policies if I sustain an injury while functioning in the formal capacity of Student, as applicable. Hospital will indemnify me for medical payments incurred as a result of accidents occurring within the scope of my duties during the clinical rotation in accordance with all limitations and conditions in Hospital's commercial general liability coverage.

Signature page follows

By signing below, I acknowledge that I have this Student Participation Agreement and Waiver, that I understand its terms, and that I agree to abide by it.

Signature of Student Date

Witness Date

ATTACHMENT B

CONSENT FOR STUDENT TO SUBMIT TO DRUG AND/OR ALCOHOL TESTING AUTHORIZATION FOR RELEASE OF TEST RESULTS, AND RELEASE OF LIABILITY

I, _____, have been informed that Catholic Health Initiatives, or the parent, affiliated or related hospital facilities (collectively "CHI" or "Hospital"), its employees or agents and/or my educational sponsoring institution, or the parent, affiliated or related facilities (collectively "Sponsoring Institution"), its employees, or agents, is requesting that I submit to drug and/or alcohol testing to detect the presence of drugs or alcohol for the following reason: (check one)

_____Post-offer/Pre-placement in clinical experiences/program ("Program") at CHI St. Joseph Health Regional Hospital ("Hospital")

_____Reasonable Suspicion/For Cause

I understand that the testing for drugs will be done by at least a 10-Panel drug screen. I further give my permission for CHI and/or Sponsoring Institution to test for drugs at a higher level panel drug screen if it chooses. If required by state law, I have received a list of substances for which I will be tested. I have been informed and I understand that my agreement to submit to the requested drug and/or alcohol test(s) is completely voluntary on my part, and that I have the right to refuse to submit to the test(s). I am aware and have been told that I may be required to produce documentation to verify information contained in this consent and that my refusal to submit to the drug and/or alcohol testing or failure to cooperate in any way will be grounds for refusal to allow me to participate in the Program.

I understand and consent to the release of the results of my drug and/or alcohol test(s) to CHI's Human Resource Department, Hospital Human Resources Manager and the Sponsoring Institution, as applicable, or their designees, as may be necessary. I understand that test results will be used to determine if I qualify to participate in the Program or have violated CHI's or Hospital's rules concerning drug/alcohol use and will be grounds for refusal to allow me to participate in the Program. I understand this information will be kept confidential and disclosed as permitted by law or as necessary per CHI, Hospital and/or Sponsoring Institution policies.

I acknowledge and agree that the sample given by me shall become the property of CHI, the Hospital and/or Sponsoring Institution and I hereby relinquish all rights to ownership and possession thereof. Fees for the initial test will be paid for by the Sponsoring Institution or me. Individuals that undergo post-offer/pre-placement testing do not have the right to request an independent lab to complete an additional analysis from the initial split sample. Following and offer of placement, other types of testing may allow a re-test and if applicable, I must request this additional test within seven (7) business days from the receipt of notification of the original test result by written request to CHI Human Resources, Hospital or the Sponsoring Institution, as applicable. I will be responsible to pay for the additional analysis requested, unless the test result is negative.

Re-disclosure: I understand that the information used and/or disclosed by this authorization may no longer be protected by federal privacy law (also known as HIPAA) and the recipient of my health information may potentially re-disclose it. However, under the Federal Substance Abuse Confidentiality Requirements, 42 CFR Part 2, the recipient may be prohibited from disclosing identifiable substance abuse information.

Expiration: This authorization will expire once stated purpose above is served.

Revocation: I understand that I may revoke the authorization to disclose results (but not my consent to be tested following provision of the sample) at any time prior to disclosure by written notice to CHI or Sponsoring Institution.

This Authorization is binding: The statements made in this authorization are binding, controlling, and I understand that they take precedence over statements made in CHI's, Hospital's or Sponsoring Institution's Notice of Privacy Practices.

I agree to **HOLD HARMLESS, RELEASE, WAIVE, DISCHARGE AND COVENANT NOT TO SUE** CHI, nor its parent, affiliates, officers, trustees, directors, contractors, providers, agents, employees, related facilities, and physicians, and/or Sponsoring Institution from any and all liability, claims, demands for injury, or other causes of action I have now or may have in the future which may arise from CHI, Hospital and/or Sponsoring Institution, or their designees requesting, performing, disclosing, and using the results of these tests.

I certify that the urine or other specimen to be collected from me will be mine and will not be adulterated, substituted, or diluted in any manner. I certify that the medications I have listed on the following page include any medications that I have taken in the last 48 hours and 30 days.

I have taken the following medications (including over the counter and/or prescription medications or other drugs) within the last **forty-eight (48) hours**:

Brand Name of Drug	Dosage (Strength Per Day)	Length of Time Used

I have taken the following medications (including over the counter and/or prescription medications or other drugs) within the last **thirty (30) days**:

Brand Name of Drug	Dosage (Strength Per Day)	Length of Time Used

Brand Name of Drug	Dosage (Strength Per Day)	Length of Time Used

I authorize CHI, Hospital and/or Sponsoring Institution to contact my physician(s) listed below to verify that the medications I have listed were lawfully prescribed.

_____

_____

_____

I hereby represent that I have read and understand the above information and have voluntarily agreed to submit to the requested drug and/or alcohol test by urinalysis, blood and/or other testing requested by the Institution at the laboratory designated, and in recognition of my agreement, sign below.

Signature_____ Date_____

Witness_____ Date_____

ATTACHMENT C

ADDITIONAL PROVISIONS

In its performance under this Agreement, RC Health Services ("Sponsoring Institution") agrees to the following additional terms, which are incorporated by reference and are made fully a part thereof. Any ambiguity or conflict shall be resolved in favor of these Additional Provisions.

1. **Compliance with CHI Standards of Conduct.** Sponsoring Institution shall comply with the Catholic Health Initiatives ("CHI") *Standards of Conduct* as set forth in the *Our Values & Ethics at Work Reference Guide*, available at http://www.catholichealthinitiatives.org/corporate-responsibility.

2. **Ethical and Religious Directives.** Sponsoring Institution shall comply with the United States Conference of Catholic Bishops' *Ethical and Religious Directives for Catholic Health Care Services*, available at http://www.usccb.org/.

3. **Legal Compliance.** Sponsoring Institution shall comply with all applicable laws, rules, and regulations.

4. **Insurance.** Sponsoring Institution shall maintain usual and customary insurance applicable to Sponsoring Institution's obligations under this Agreement, including minimum coverage amounts of: $1,000,000 USD per occurrence and $3,000,000 USD annual aggregate for each of commercial general and professional liability; $1,000,000 USD per occurrence for automobile liability; and applicable statutory limits for workers' compensation. These coverage limits are not intended to limit Sponsoring Institution's liability. If any of Sponsoring Institution's insurance policies are "claims-made" policies, Sponsoring Institution shall purchase "tail" coverage upon the termination of such policy. Such "tail" coverage shall provide for an indefinite reporting period. Upon reasonable request, Sponsoring Institution shall provide proof of applicable insurance policies to CHI St. Joseph Health Regional Hospital ("Hospital").

5. **Access to Records.** If required by 42 U.S.C. § 1395x(v)(1)(I), until the expiration of four (4) years after the termination of this Agreement, Sponsoring Institution shall make available, upon written request by the Secretary of the Department of Health and Human Services, or upon request by the Comptroller General of the United States General Accounting Office, or any of their duly authorized representatives, a copy of this Agreement and such books, documents, and records as are necessary to certify the nature and extent of the costs of the services provided by Sponsoring Institution under this Agreement. If Sponsoring Institution carries out any of its duties under this Agreement through a subcontract with a value or cost of $10,000 or more over a twelve (12) month period, such subcontract shall contain the same requirements.

6. **Breach of Additional Provisions.** If Hospital determines in good faith that Sponsoring Institution has failed to comply with its obligations pursuant to Additional Provisions 1 through 5, Sponsoring Institution shall be in material breach of this Agreement, and Hospital may terminate this Agreement without penalty, effective immediately upon notice.

7. **No Exclusion/Debarment.** Sponsoring Institution warrants that neither it nor its principals or employees are, or have been, excluded, debarred, suspended, proposed for debarment, or declared ineligible from participation in any federally funded program ("Exclusion"). Sponsoring Institution shall immediately notify Hospital of any threatened or actual Exclusion. If Sponsoring Institution is so debarred, suspended, or excluded, this Agreement shall immediately and automatically terminate. Sponsoring Institution shall indemnify and defend Hospital against all actions, claims, demands, liabilities, losses, damages, costs, and expenses, including reasonable attorneys' fees, arising directly or indirectly out of any Exclusion.

8. **Jeopardy.** If Hospital reasonably determines that the continued performance of this Agreement jeopardizes Hospital's or any of its affiliated entities' (i) licensure, (ii) participation in or recovery from any reimbursement or payment programs, (iii) accreditation status, or (iv) tax exempt or bond financing status, Hospital shall notify Sponsoring Institution so the parties may resolve the issues. If no resolution is reached within 15 days, Hospital may terminate this Agreement immediately and without penalty.

ATTACHMENT D

Description of Programs

EMT Internship Objectives

***Because of patient availability, it is possible that all objectives may not be met and that all skills may not be performed. Nonetheless, as many skills as possible should be observed and practiced by the student.

1. Tour and receive orientation to the assigned area.
2. Perform equipment/vehicle checks and any other preparatory tasks.
3. Utilize "Universal Precautions" of infection control.
4. Perform a patient assessment:
    a) Primary survey
    b) Secondary survey
    c) Vital signs, including lung sounds
    d) History
5. Assist and observe the triage of patients.
6. Perform airway management:
    a) Manual techniques
    b) Oropharyngeal airways
    c) Nasopharyngeal airways
    d) Oropharyngeal suctioning
7. Perform respiratory support:
    a) Oxygen administration
    b) Bag-valve mask ventilation
    c) Demand valve resuscitators
8. Perform CPR:
    a) Observe and assist in cardiac resuscitation
    b) Observe and assist in trauma resuscitation
    c) Observe and assist in the use of the Automatic External Defibrillator (AED)
9. Recognize and evaluate mechanisms of injury.
10. Assist in the treatment of trauma cases:
    a) Perform bleeding control
    b) Dress and bandage wounds
    c) Perform musculoskeletal immobilization
    d) Apply traction splint
    e) Assist with spinal immobilization
    f) Penetrating wounds of the chest and abdomen
    g) Other trauma cases as available
11. Assist in the treatment of medical cases:
    a) Chest pain
    b) Assist in the administration of nitroglycerine
    c) Congestive heart failure
    d) Chronic obstructive pulmonary disease
    e) Obstructed airway

f) Asthma attack
    i. Assist in the administration of the metered dose inhaler
    ii. Assist in the administration of nebulizer treatment
g) Diabetic emergencies
    i. Assist in the use of the glucometer
    ii. Assist in the administration of an instant glucose product
h) Seizures
i) Coma
j) Overdose (alcohol or drug abuse)
    i. Assist in the administration of Activated Charcoal
k) Other medical cases as available
l) Anaphylactic Shock
    i. Assist in the administration of the epinephrine auto-injector

12. Assist or observe the care pf behavioral emergencies:
    a) Suicidal behavior
    b) Hostile/violent behavior
    c) Acute grief or depression
    d) Paranoia
    e) Hysterical conversion
    f) Acute anxiety/agitation
    g) Schizophrenia
    h) Anger
    i) Confusion
    j) Fear
    k) Hyperactivity
    l) Alcohol and drug abuse
    m) Other behavioral cases which are safely available
13. Assist in the care of geriatric patients:
    a) Senility
    b) Alzheimer's disease
    c) Osteoporosis
    d) Rheumatoid arthritis
    e) Immobility
    f) Other geriatric cases as available
14. Assist in the care of pediatric patients:
    a) Signs and symptoms of pediatric illness
    b) Febrile seizures
    c) Restraint procedures
    d) Psychological states of age progression
    e) Note vital sign differences
    f) Parental care
    g) Poisonings
    h) Other pediatric cases as available

15. Assist or observe the care of obstetric patients:
    a) Identify the three stages of labor
    b) Cephalic delivery
    c) Clamping and cutting of the umbilical cord
    d) Complications of delivery
    e) Observe a caesarian section
    f) Note medications given to the mother
    g) Inspect the delivered placenta and umbilical cord
    h) Postpartum hemorrhage control
    i) Newborn care
    j) APGAR scoring
    k) Premature infant care
    l) Fetal monitoring
    m) Other obstetric cases as available
16. Observe the management of cases with legal implications or which require evidence preservation:
    a) Sexual assault/rape
    b) Child/elderly abuse
    c) Shootings/stabbing
    d) Animal bites
    e) Other cases as available
17. Observe sterile techniques and assist as directed.
18. Assist in lifting, moving and patient transfers.
19. Perform patient access, packaging and extrication.
20. Assist in any restocking, cleaning or other duties as assigned in the clinical/field facility.
21. Observe diagnostic procedures/tests and review lab results.
22. Review charts for clinical findings, diagnosis and treatment plans.
23. Monitor and record radio and oral communication of patient information.
24. Document, for student records, patient and/or incident information.
25. Assist or observe in any procedure authorized by the attending physician and/or preceptor that will increase the understanding of anatomy and physiology of illness or injury.

AEMT Internship Objectives

*** Because of patient availability, it is possible that all objectives may not be met and that all skills may not be performed. Nonetheless, as many skills as possible should be observed and practiced by the student.

1. All internship objectives for the EMT.
2. Perform an advanced patient assessment using the following:
    a) Auscultation
    b) Inspection
    c) Percussion
    d) Palpation
3. Perform or observe advanced airway management:
    a) Esophageal obturator
    b) Endotracheal intubation
    c) Nasotracheal intubation
    d) Endotracheal suctioning with sterile technique
    e) Tracheotomy care
    f) Chest decompression
    g) Cricothyrotomy
    h) Transtracheal jet insufflation
    i) Laryngeal Mask Airway
    j) Combitube
4. Perform advanced respiratory support:
    a) Note arterial blood gas values and changes relative to oxygen therapy
    b) Ventilate intubated patients with the bag-valve mask unit
    c) Note and monitor lung sounds (rales, rhonchi, wheezes, and diminished lung sounds)
5. Assist in the advanced treatment of trauma cases:
    a) IV fluid challenges or fluid replacement
    b) Apply MAST, when indicated, to stabilize pelvic and lower extremity fractures
6. Assist in the advanced treatment of medical cases:
    a) IV care
    b) Assist with medication administration
7. Assist and observe IV fluid administration:
    a) Fluid type used for patient's condition
    b) Rate of administration
    c) Type of IV tubing
    d) Drip rate calculation
    e) IV set up procedures
    f) Note IV sites used
    g) Observe intraosseous infusions
8. Observe blood or blood product transfusions:
    a) Blood type and cross match procedures

b) Note product type used for patient condition
c) Observe for signs or symptoms of hemolytic reaction

9. Perform IV insertions under supervision of the clinical instructor:
   a) External jugulars
   b) Establish with a butterfly catheter
   c) Establish with an over-the-needle catheter
   d) Set the prescribed drip rate
   e) Peripheral sites
   f) Intraosseous cannulation
10. Draw blood samples: (Not to include ABG's, blood alcohol, or blood for highly sophisticated laboratory analysis)
   a) Students are permitted two attempts per patient
   b) Demonstrate aseptic technique
   c) Use a vacutainer
   d) Use a needle and syringe
   e) Use an over-the-needle catheter (agiocath) and syringe
   f) Use a scalp vein needle (butterfly) and syringe
11. Document advanced procedures appropriately:
   a) Non-visualized airway tube placement
   b) Endotracheal intubation
   c) IV insertions
12. Assist or observe in any procedure authorized by the attending physician and/or preceptor that will increase the understanding of anatomy and physiology of illness or injury.

Medications allowed:

- • Oxygen
- • Oral glucose
- • Glucagon
- • IV Dextrose
- • IV fluids
- • Epinephrine (IM or SQ)
- • MDI medications
- • Nebulized Medications
- • Nitroglycerin – spray, tablets, paste
- • Nitrous Oxide
- • Naloxone
- • Aspirin