EXHIBIT A

STUDENT PARTICIPATION AGREEMENT AND WAIVER

I, _____, am student at _____
[*Insert name of educational institution here*] ("Sponsoring Institution") during which I will be participating in a clinical rotation at **CHI St. Vincent** ("Hospital") or one of its Educational Sites. 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 under a physical health exam before the clinical education rotation begins to include immunizations and tests, per CDC guidelines for: (i) must have either started the Hepatitis B vaccination series, have a positive titer or have a declination on file; (ii) TB Screening skin test (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 during my school clinical rotations, I am not in the role of 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 worker's 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. I understand that instructions for clinical care come from my clinical instructors. Should I have a question on what care I am allowed to provide, I will consult my clinical instructors.

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 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 reviewed CommonSpirit's Compliance Booklet and the ***Ethical and Religious Directives for Catholic Healthcare Services at the links below.,*** and agree to comply with the terms of these documents and all hospital policies.

https://www.commonspirit.org/content/dam/commonspirit/pdfs/CommonSpirit_ComplianceBooklet07-16-21_vf-s.pdf

https://www.usccb.org/resources/ethical-and-religious-directives-catholic-healthcare-services

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.

15. I understand that I am not an employee of the Hospital, but rather am participating in this training program for the benefit of fulfilling requirements related to my education at the Sponsoring Institution.

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

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