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 Del Mar College ("School") at School District unless such injury or loss arises solely out of School District 's gross negligence or willful misconduct.

_____ _____

Signature of Program Participant Date

Print Name: _____

_____ _____

Parent or Legal Guardian if Program Participant is under 18 Date

Print Name: _____

Relationship to Program Participant: _____

EXHIBIT B

PROTECTED HEALTH INFORMATION, CONFIDENTIALITY, AND SECURITY AGREEMENT

- Protected Health Information (PHI) includes patient information based on examination, test results, diagnoses, response to treatment, observation, or conversation with the patient. This information is protected and the patient has a right to the confidentiality of his or her patient care information whether this information is in written, electronic, or verbal format. PHI is individually-identifiable information that includes, but is not limited to, patient's name, account number, birth date, admission and discharge dates, photographs, and health plan beneficiary number.
- Medical records, case histories, medical reports, images, raw test results, and medical dictations from healthcare facilities are used for student learning activities. Although patient identification is removed, all healthcare information must be protected and treated as confidential.
- Students enrolled in school programs or courses and responsible faculty are given access to patient information. Students are exposed to PHI during their clinical rotations in healthcare facilities.
- Students and responsible faculty may be issued computer identifications (IDs) and passwords to access PHI.

Initial each to accept the Policy

Initial	Policy
	1. It is the policy of the school/institution to keep PHI confidential and secure.
	2. Any or all PHI, 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.
	3. Whether at the school or at a clinical site, students are not to discuss PHI, in general or in detail, in public areas under any circumstances, including hallways, cafeterias, elevators, or any other area where unauthorized people or those who do not have a need-to-know may overhear.
	4. Unauthorized removal of any part of original medical records is prohibited. Students and faculty may not release or display copies of PHI. Case presentation material will be used in accordance with healthcare facility policies.
	5. Students and faculty shall not access data on patients for whom they have no responsibilities or a "need-to-know" the content of PHI concerning those patients.
	6. A computer ID and password are assigned to individual students and faculty. Students and faculty are responsible and accountable for all work done under the associated access.
	7. Computer IDs or passwords may not be disclosed to anyone. Students and faculty are prohibited from attempting to learn or use another person's computer ID or password.
	8. Students and faculty agree to follow Hospital's privacy policies.
	9. Breach of patient confidentiality by disregarding the policies governing PHI is grounds for dismissal from the Hospital.

- I agree to abide by the above policies and other policies at the clinical site. I further agree to keep PHI confidential.
- I understand that failure to comply with these policies will result in disciplinary actions.
- I understand that Federal and State laws govern the confidentiality and security of PHI and that unauthorized disclosure of PHI is a violation of law and may result in civil and criminal penalties.

_____ _____

Signature of Program Participant Date

Print Name: _____

_____ _____

Parent or Legal Guardian if Program Participant is under 18 Date

Print Name: _____

Relationship to Program Participant: _____

EXHIBIT C

Student Attestation Form

***Please fill in dates below when each item was completed**

Students fill out first TWO sections only

Student Name: _____ School: Del Mar College _____

Field of Study: _____ Social Security #: _____

Drivers License Information

Drivers License #: _____ Exp. Date: _____

Verification Date: _____ State(s): _____

Health Information

Physician statement (within the last year): _____

PPD (within the last 90 days): _____

Hepatitis B Vaccine: _____ Declined Date: _____

10 Panel Drug Screen (within last 30 days) Result: _____ Date: _____

MMR Date: _____ Titer: _____

Varicella Titer: _____ (positive by history)

Education

OSHA/Blood Borne Pathogen (in-service date): _____

Facility Orientation/Code of Conduct (training date): _____

Background Investigation

Motor Vehicle: _____

Social Security number verification: _____

Criminal Search (up to 7 years or up to 5 searches): _____

Employment verifications (last 2): _____

HHS/OIG/GSA list of **excluded** individuals: _____

Texas HHS list of **excluded** individuals: _____

Violent sexual offender & Predator registry search: _____

Education verification (highest degree received): _____

**** If information in not applicable to the contract employee, please mark with N/A***

As a designated representative of the School named below, I attest that the above information is present in this student's file, and that the above named student has been determined to be competent for the field of study and assigned area.

School Name: Del Mar College – Nursing Education

School Representative & Title: _____ Date: _____