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**

<table>
<thead>
<tr>
<th>Initial</th>
<th>Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>It is the policy of the school/institution to keep PHI confidential and secure.</td>
</tr>
<tr>
<td>2.</td>
<td>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.</td>
</tr>
<tr>
<td>3.</td>
<td>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.</td>
</tr>
<tr>
<td>4.</td>
<td>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.</td>
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<tr>
<td>5.</td>
<td>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.</td>
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<tr>
<td>6.</td>
<td>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.</td>
</tr>
<tr>
<td>7.</td>
<td>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.</td>
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<tr>
<td>8.</td>
<td>Students and faculty agree to follow Hospital’s privacy policies.</td>
</tr>
<tr>
<td>9.</td>
<td>Breach of patient confidentiality by disregarding the policies governing PHI is grounds for dismissal from the Hospital.</td>
</tr>
</tbody>
</table>

- 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: ____________________