ADDENDUM TO AGREEMENT BETWEEN
NORTHSIDE HOSPITAL
AND
THE BOARD OF REGENTS OF THE UNIVERSITY SYSTEM OF GEORGIA BY AND ON BEHALF OF
GEORGIA STATE UNIVERSITY

This Addendum to the Memorandum of Agreement between Northside Hospital, Inc. d/b/a Northside Hospital and The Board of Regents of the University System of Georgia by and on behalf of Georgia State University is entered into as of September 19, 2019.

1. The Memorandum of Agreement between Northside Hospital and Emory University, dated to expire on October 4, 2022 will now apply to the program listed on Exhibit A.

2. All other terms and provisions of the Memorandum of Agreement shall remain in full force and effect.

3. Clinical Program subject to this Addendum, Exhibit A (attached).

INSTITUTION

The Board of Regents of the
University System of Georgia by and on
Behalf of Georgia State University
P.O. Box 3995
Atlanta, GA 30302-3995

By: _____
(Signature)

Print Name: Wendy Hensel

Title: Provost & Sr. VP for Academic Affairs

Date: September 30, 2019

By: _____
(Signature)

Print Name: _____

Title: _____

Date: _____

FACILITY

Northside Hospital, Inc.
1000 Johnson Ferry Road NE
Atlanta, GA 30342

By: Janis Dubow
(Signature)

Print Name: Janis Dubow

Title: VP & Chief Nursing Officer

Date: 2-4-20

EXHIBIT A
Addendum to Agreement between
Northside Hospital and The Board of Regents of the University System of Georgia by and on behalf of
Georgia State University

CLINICAL PROGRAM SUBJECT TO THIS ADDENDUM TO AGREEMENT

Doctor of Nursing Practice

This Addendum to Agreement expires on October 4, 2022.

FACILITY

Agreed to by Facility: Janis Dubow (Signature) Print Name: Janis Dubow

Title: VP & Chief Nursing Officer Date: 2-4-20

INSTITUTION

Institution: Wendy Hensel (Signature) Print Name: Wendy Hensel

Title: Provost & Sr. Vice President of Academic Affairs Date: September 30, 2019

Institution: _____ (Signature) Print Name: _____

Title: _____ Date: _____

EXHIBIT B

STUDENT AND FACULTY HEALTH HISTORY QUESTIONNAIRE

NORTHSIDE HOSPITAL
Atlanta · Cherokee · Forsyth

NORTHSIDE HOSPITAL HEALTH HISTORY FORM INSTRUCTIONS

Provide documentation for Questions 1-4 & 11-12

- Annual Tuberculosis Skin Test /TST (PPD) is required.
- All dates must be in the form of month/day/year.
- Documentation must include official/authorized healthcare provider signature.
- Please submit one of the following as proof of immunization:
  1. Personal immunization record
  2. School medical records

Tuberculosis Skin Test/TST (PPD):

- **Negative TST (PPD) Skin Test:**
  - Must provide documentation of current negative TST (PPD) results within the past one year (results must cover duration of clinical rotation)

- **Positive TST (PPD) Skin Test Requirements:**

  To be assigned to a unit/department, you must meet **ONE** of the following:

  1. Annual Negative Quanti-FERON Gold blood test (recommended with prior BCG vaccination)

     OR

  2. Annual Negative T-SPOT blood test

     OR

  3. Provide documentation of the following:
     - Must provide documentation of first positive reading/results
     - Must have negative screening for symptoms of TB
     - Must have chest x-ray or radiology report within the past year
     - Must be evaluated by residential county health department **AND** provide evidence of taking or have taken prophylactic therapy if working in one of our high risk areas which include Women's Services, Bone Marrow and Oncology, Child Development Center and ICU. Other units will be considered on an individual basis.

NORTHSIDE HOSPITAL
Atlanta • Cherokee • Forsyth

NORTHSIDE HOSPITAL HEALTH HISTORY FORM

Please Check One:
- ☐ Faculty
- ☐ Student
- ☐ Other

School _____ Dates of clinical experience at Northside Hospital_____

Name

(Print)_____Sex_____Age_____

Home Address_____Phone_____

School ID Number _____ Birth Date

_____

In case of emergency, please notify_____

Address_____Phone_____Relation_____

Area of the hospital in which you will be working (list all areas) _____

Are you a Northside Hospital employee? ☐ Yes ☐ No **If "Yes" STOP, go to Page 2 and sign.**

If "Yes" Department/Unit Name: _____

Annual Tuberculosis Test/TST (PPD) is required.
For Questions 1-4, please attach supportive documentation

1. Have you had an Influenza Vaccine for the current calendar year October – March?
   ☐ Yes Date____/_____/_____
   ☐ No, please check one of the reasons listed below:

   ☐ A severe allergic reaction to eggs or other components of the influenza vaccine,

   ☐ A history of Guillian-Barre' Syndrome (a severe paralytic illness, also called GBS) within 6 weeks after a previous influenza vaccination

   (Submit medical documentation of the contraindication identified).

2. Have you had a skin test for Tuberculosis within the past one year? ☐ Yes ☐ No **(obtain Tuberculosis test)**

   If **"Yes"**, date____/_____/_____Results_____ (Must provide supporting document)

3. Have you ever had a positive skin test for Tuberculosis? ☐ Yes ☐ No
   - If **"Yes"**, date of first positive skin test reading____/_____/____Results_____ (Must provide supporting document)
   - Have you been treated for a positive PPD? ☐ Yes ☐ No If **"Yes"**, dates From _____ To ____

     _____

     Medications given (Must provide supporting document) _____

4. Have you had a Chest X-ray within the past year? ☐ Yes ☐ No Date____/_____/_____
   If **"Yes"**, provide copy of radiology report from your physician describing your x-ray report results.

NORTHSIDE HOSPITAL HEALTH HISTORY FORM *(continued)*

Name_____

If you have a positive skin test, please complete the following surveillance screening (annually)

Have you ever had any of the following? Check (✓) all that apply.

- ☐ Positive reaction to a TST (PPD) skin test
- ☐ Taken medication for + TB skin test
- ☐ Productive cough lasting more than 3 weeks
- ☐ Unexplained fever, chills, or night sweats
- ☐ Coughing up blood
- ☐ Known exposure to active TB
- ☐ Unexplained weight loss
- ☐ None of the above

5. Have you experienced any condition(s) that would or does render you physically incapable of performing the activities of your educational program here at Northside Hospital? _____

6. Have you ever been treated for any serious illness or injury (including any back, neck or shoulder injury)? If so, list the name of the problem, dates, results, and present status.

_____

7. To the best of your knowledge do you currently have a contagious disease? ☐ Yes ☐ No

8. Are you currently under a physician's care? ☐ Yes ☐ No If **"Yes"**, please give physician's name: _____

9. List medication(s) you are presently taking.

Medication	Dosage	Drug	Dosage

10. Do you have a Latex allergy? ☐ Yes ☐ No

List any other allergies _____

For Questions 11-12, please attach supportive documentation
(Titers must include results to determine immunity)

11. Must answer **ONE** of the following criteria?

If you were **BORN BEFORE 1957**:	If you were **BORN AFTER 1957**:
A. Have you had a positive titer for Rubella (German Measles)? ☐ Yes ☐ No **If "No", go to "B"**	A. Do you have proof of 2 MMR vaccines? ☐ Yes ☐ No **If "No", go to "B"**
B. Have you had a Rubella vaccine? ☐ Yes ☐ No **If "No", go to "C"**	B. Documentation of one MMR and one Rubeola vaccine or positive Rubeola titer? ☐ Yes ☐ No **If "No", go to "C"**
C. Have you had one dose of MMR vaccine? ☐ Yes ☐ No	C. Have you had positive titers for Rubella and Rubeola (Red Measles)? ☐ Yes ☐ No
If **"No"** to all the above, you must obtain a **Rubella Titer** and provide result.	If **"No"** to all the above, you must obtain **Titer(s)** for Rubella and Rubeola and provide result(s).

12. Have you had one of the following?
    - A. Chicken Pox? ☐ Yes ☐ No If, **"Yes"**, When? _____/_____/_____
    - B. Lived with a family member who has had documented chicken pox? ☐ Yes ☐ No
    - C. Chicken Pox (Varicella) vaccine? ☐ Yes ☐ No If **"Yes"**, When? _____/_____/_____
    - D. Have you had a positive titer for Varicella? ☐ Yes ☐ No

NORTHSIDE HOSPITAL HEALTH HISTORY FORM *(continued)*

Name_____

PLEASE READ CAREFULLY BEFORE SIGNING:
I certify that all information provided in this questionnaire is true and correct to the best of my knowledge. I understand that any falsification or significant omission of any information requested herein will be considered sufficient cause for withdrawal from the facility without prior warning at any time during my affiliation with Northside Hospital.

I further authorize any hospital, clinic or physician(s) to release to Northside Hospital any information relative to my medical history, physical and mental condition for purposes of verifying the information provided on this form, determining my ability to perform my assignment. I further agree that this authorization will be valid throughout my assignment at Northside Hospital.

Signature _____ Date _____

EXHIBIT C
REQUIRED RECORDS FOR STUDENT PARTICIPANTS

FOR STUDENTS WHO ARE NOT NORTHSIDE HOSPITAL EMPLOYEES:

**Submit Full Legal name only (No Nickname) **

- Background Check & Drug Screen Results
- Department/Unit Orientation (Provided by Northside Hospital Preceptor)
- Healthcare Provider Basic Life Support - BLS (If required)
- Northside Hospital Acknowledgement and Release Form
- Northside Hospital Confidentiality/Security Agreement
- Northside Hospital Health History Form
- Northside Hospital Student Skills Checklist (For each semester)
- On-Line Orientation from Student page of Northside Hospital website (Each student must review orientation presentations prior to signing the Acknowledgement and Release Form)
    - Ebola Education
    - General Orientation
    - HIPAA Compliance & Code of Conduct
- Professional Liability Insurance
- Proof of required Immunizations (Must have authorized Healthcare Provider's signature)
- Syllabus and Course Objectives (For each semester)
- Validation of Current Licensure (if appropriate)

FOR STUDENTS WHO ARE NORTHSIDE HOSPITAL EMPLOYEES:

**Submit Full Legal name only (No Nickname) **

- Background Check & Drug Screen Results[1]
- Department/Unit Orientation (Provided by Northside Hospital Preceptor)
- Healthcare Provider Basic Life Support - BLS (If required)
- Northside Hospital Employee Participating in Clinical Training Program Form
- Northside Hospital Health History Form
- Northside Hospital Student Skills Checklist (For each semester)
- Professional Liability Insurance

1. For Students that are also Northside Hospital, Inc. Employees, the Background Check and Drug Screen results statuses will be confirmed by the Northside Hospital, Inc. Human Resources department to satisfy this requirement in accordance with Northside Hospital, Inc. policy.