MEMORANDUM OF AGREEMENT

This Agreement between Northside Hospital, Inc. d/b/a Northside Hospital, Northside Hospital Forsyth and Northside Hospital Cherokee ("Facility"), and The Board of Regents of the University System of Georgia by and on behalf of Georgia State University ("Institution") sets forth the ways in which Facility and Institution will cooperate for the fulfillment of clinical education requirements of the Institution.

A. PURPOSE.

1. Facility and Institution desire to cooperate in the provision of clinical experiences at Facility for students of the Institution's Advanced Practice Registered Nursing program.

2. Institution has or will enter into one or more agreements with licensed physicians or their medical practice groups (each a "Sponsoring Physician" or "Sponsoring Agency") to provide on-site supervision and other services related to the students. The Institution will obtain and provide to Facility each Sponsoring Agency's/ Sponsoring Physician's Acknowledgment of this Memorandum of Agreement in substantially the form of Exhibit A, attached hereto.

3. The purpose of this Memorandum of Agreement is to guide and direct the parties respecting their affiliation and working relationship, inclusive of anticipated future arrangements and agreements in furtherance thereof, to provide high quality clinical learning experiences for the Institution's students, while at the same time enhancing the educational community goals of the Facility pursuant to its Mission and Values Statement.

4. Except as specified herein, none of the parties intend for this Memorandum to alter in any way their respective legal rights or their legal obligations to any other party, to the students assigned to the Facility, or as to any third party. No party is an agent, employee or servant of any other party. All parties are independent contractors with respect to any other party.

B. GENERAL UNDERSTANDING:

1. The clinical education program(s) ("Program(s)") to be provided will be of such content and cover such periods of time as may from time to time be mutually agreed upon by the Institution, the Sponsoring Agency or Sponsoring Physician and the Facility. The starting and ending date for each Program shall be agreed upon before the Program commences. The Program and student assignments shall be subject to the Northside Hospital Medical Staff Student Affiliation Policy as may be from time to time amended.

2. The number of students designated for participation in a Program will be mutually determined by agreement of the parties, and may be altered at any time by mutual agreement. All student participants must be mutually acceptable to the parties and any party may request removal of any student from a Program based upon perceived lack of competency on the part of the student, the student's failure to comply with the rules and policies of the Facility or the Institution, or for any other reason if any party reasonably believes that it is not in the best interest of the Program for the student to continue. Such party shall provide the Institution with immediate request for removal and written reasons for the requested removal. It shall be the Institution's responsibility to remove any such student immediately upon the request of a party hereto.

3. There shall be no discrimination on the basis of race, national origin, religion, creed, sex, sexual orientation, age, disability or veteran's status in either the selection of students for participation in the Program, or as to any aspect of the clinical training; provided, however, that with respect to disability, the disability must not be such as would, even with reasonable accommodation, in and of itself preclude the student's effective participation in the Program.

C. FACILITY RESPONSIBILITIES.

1. The Facility and Sponsoring Agency/Sponsoring Physician will retain responsibility for the care of patients. Facility will not use students to perform services in lieu of staff.

2. The Facility will provide adequate facilities for participating students in accordance with the clinical objectives developed through cooperative planning by the Sponsoring Agency/Sponsoring Physician and Facility.

3. The Facility shall provide for the orientation of participating students to the facilities, philosophies, rules, regulations and policies of the Facility.

4. The Institution and the Facility acknowledge and agree that student participants in the Program are not employees of the Facility because of such participation, and that the Facility assumes no responsibilities as to the participants that may be imposed upon an employer under any law, regulation or ordinance. Program participants are not entitled to employee benefits and shall in no way hold themselves out as employees of the Facility. The parties agree that the Facility does not control the time, manner or method in which participants perform services.

5. The Facility will procure and maintain for its respective employees professional and comprehensive general liability insurance in minimum amounts of $1,000,000 per occurrence and $3,000,000 annual aggregate and will provide evidence of such insurance to the other parties prior to beginning of the Program. It is agreed that Facility may choose to provide such coverage through a program of self-insurance.

6. To the extent not covered by applicable policies of insurance, or as otherwise provided under this Agreement, the Facility shall defend, indemnify and hold the Institution harmless from and against any claim, liability, loss, damage, cost or expense of any kind, including, but not limited to, reasonable attorneys' fees (collectively, the "Damages"), arising out of or related to any breach by the Facility, the Facility's affiliated entities, shareholders, officers, employees, contractors or agents in the performance of their respective covenants hereunder, except to the extent that such Damages result from a breach of this Agreement by the Institution.

D. INSTITUTION RESPONSIBILITIES:

1. The Institution will use its best efforts to see that students selected for participation in the Program are prepared for effective participation in the clinical training phase of their overall education. The Institution will retain ultimate responsibility for the education of its students.

2. The Institution will use its best efforts to see that the Programs at the Facility are conducted in such a manner as to enhance patient care. Only those students who have satisfactorily completed the prerequisite didactic portion of their curriculum will be selected for participation in a Program. The Facility, Sponsoring Agency /Sponsoring Physician and the Institution agree that no participants shall be permitted to engage in any aspect of patient care for which they are not trained or certified by the Institution.

3. The Institution will procure and maintain, or require participating students and faculty to procure and maintain, throughout the Program professional liability insurance with minimum limits of One Million Dollars (US $1,000,000) per occurrence and Three Million Dollars (US $3,000,000) annual aggregate and covering the activities of students and faculty at the Facility. All insurance must be issued by a licensed insurer rated B++ and financial size category VI or greater in the most recent Best's Insurance Reports Evidence of such insurance musts be provided to the Facility prior to participation in the Program. It is agreed that Institution may choose to provide such coverage through a program of self-insurance.

4. Each party shall be responsible for its own acts and omissions and those of its employees, agents and representatives under this agreement. Acts and omissions of Institution's students in the scope of activity are covered by an insurance policy with limits in amount of $1,000,000 per occurrence and $3,000,000 per aggregate.

5. The Institution will encourage student compliance with the Facility's rules, regulations and procedures. Facility will make available to the students the Facility rules, regulations and procedures. Specifically, the Institution will keep each participating student apprised of his or her responsibility to follow the rules, regulations and procedures of Facility:

a. To follow the administrative policies, standards and practices of the Facility when the student is in the Facility;

b. To provide the necessary and appropriate uniforms and supplies required when not provided by the Facility;

c. To report to the Facility on time and to follow all established regulations during the regularly scheduled operating hours of the Facility;

d. To conform to the standards and practices established by the Institution while training at the Facility; and

e. To keep in confidence all medical and health information pertaining to patients of the Facility.

6. The Institution will require that all students prior to participation in the Program undergo a physical examination (including PPD test or chest x-ray, hepatitis-B core antibody test, and Rubella and measles tests or documentation of immunization) as may be necessary to determine that they are free from any infectious or contagious diseases and are physically able to perform their activities in the Program in order to ensure that students do not pose a direct threat to the health or safety of others. At the Facility's request, the Facility shall be given full access to the records relating to such examinations. The Institution shall obtain the student's consent to release of such information to the Facility at the time the student enrolls in the Program. At the option of the Facility, such physical examinations may be performed by the Facility, at the sole expense of the students. No student shall be permitted to carry on any activities in proximity with Facility patients if the student is ill or unwell in any way and such illness poses a direct threat to the health or safety of others. The Institution shall inform the students of the importance of having in force at all times a health insurance policy to defray the cost of care of any illness or injury that may be sustained while participating in any clinical training. Any medical or health care (emergency or otherwise) that may be received by an Institution student at the Facility in the course of the Program shall be at the sole expense of the individual recipient of such care, unless such care is due to the negligent or intentional acts or omissions of the Facility; provided that nothing herein shall require the Facility to provide any such care, with the exception of provisions made in Section F.4 regarding student emergency care and needle sticks.

7. The Institution shall have the full responsibility for the conduct of any student disciplinary proceedings and shall conduct the same in accordance with Institution's own policies and procedures. Both parties agree to cooperate with each other and share information in the event that any investigation is conducted with respect to a student's experience or performance at Facility. Students may be asked to sign a form granting School and Facility permission to share information relevant to his or her experience or performance.

8. The Institution agrees to notify the other parties as soon as possible in writing of any incident, occurrence or claim arising out of or in connection with this Agreement which could result in a liability or claim of liability to a party. Further, the notified party will have the right to investigate said incident or occurrence and the Institution will cooperate fully in this investigation.

E. SPONSORING AGENCY/SPONSORING PHYSICIAN RESPONSIBILITIES.

Each Sponsoring Agency will designate one or more physicians with Medical Staff membership at Facility to serve as Sponsoring Physicians pursuant to the Facility's Medical Staff Student Affiliation policy. Sponsoring Physicians will be responsible for the supervision and direction of the student at Facility with respect to the Program. Sponsoring Agency/Sponsoring Physician will not use students to perform services in lieu of staff.

F. MUTUAL RESPONSIBILITIES:

1. No provision in this Agreement shall prevent any patient from requesting not to be a teaching patient or prevent any member of the Facility medical staff from designating any patient as a non-teaching patient.

2. There shall be no monetary consideration paid by any party to the other, it being acknowledged that the Program hereunder is mutually beneficial. The parties will cooperate to promote an environment that will maximize the mutual benefits to the clinical experiences and patient care. At the instance of any party a meeting or conference will be promptly held between the parties' representatives to resolve any problems or develop any improvements in the operation of the Program.

3. This Agreement is intended solely for the mutual benefit of the parties hereto, and there is no intention, express or otherwise, to create any rights or interests for any party or person other than Facility, Sponsoring Agency or Sponsoring Physician and the Institution; without limiting the generality of the foregoing, no rights are intended to be created for any patient, student, parent or guardian of any student, spouse, next of kin, employer or prospective employer of any student.

4. Facility, Sponsoring Agency/Sponsoring Physician and Institution acknowledge that protection of students in the Program from exposure to blood-borne pathogens is the collective concern of Facility, Sponsoring Agency/Sponsoring Physician Institution and the student. Facility will make available to students for use within the Facility all personal protective equipment, including gloves, gowns, airways, and other supplies necessary to comply with Centers for Disease Control guidelines, as appropriate to the student's Program. Facility shall provide students with education regarding bloodborne pathogens appropriate to the student's clinical training at Facility, and, shall maintain documentation of such education.

Facility will provide immediate first aid for illnesses or injuries, including needle sticks that occur at Facility. The cost of such immediate first aid will be the responsibility of the student. Facility will use its best efforts to test the source patient appropriately and to obtain that patient's consent to disclosure of test results to Institution.

5. The Institution, Facility and Sponsoring Agency/Sponsoring Physician acknowledge and agree that no party shall be responsible for any loss, injury or other damage to the person or property of any student participating in the Program unless such loss, injury or damage results from the negligence or intentional misconduct of that party, its students, officers or employees, as applicable.

6. All notices or other communication provided for in this Agreement shall be given to the parties addressed as follows:

INSTITUTION

Georgia State University
Brydine F. Lewis School of Nursing and Health Professions
P.O. Box 3995
Atlanta, GA 30302-3995
Attn: Paulester Jefferson

FACILITY

Northside Hospital, Inc.
1000 Johnson Ferry Road NE
Atlanta, GA 30342
Attn: Marsha Blakey, Contracts Specialist

7. Any party may change its address or contact person for purposes of this section by written notification to the other parties, which change shall be effective upon receipt by the other parties.

8. The term of this Agreement shall be one year from the date of execution, and this Agreement shall be renewed automatically for additional one year terms; provided, however, that this Agreement may be terminated at any time by either party upon not less than thirty (30) days written notice in advance of the next educational experience.

9. The Institution, the Sponsoring Agency/Sponsoring Physician and the Facility each agree to comply, and the Institution shall advise the students to comply, with the applicable provisions of the Administrative Simplification section of the Health Insurance Portability and Accountability Act of 1996, as codified at 42 U.S.C. § 1320d through d-8 ("HIPAA"), and the requirements of any regulations promulgated thereunder, including, without limitation, the federal privacy regulations as contained in 45 CFR Parts 160 and 164 (the "Federal Privacy Regulations") and the federal security standards as contained in 45 CFR Part 164 (the "Federal Security Regulations"). The Institution, the Sponsoring Agency/Sponsoring Physician and the Facility each agree not to use or further disclose, and the Institution shall advise the students to not use or further disclose, any protected health information, as defined in 42 U.S.C. § 1320d and 45 CFR § 164.501(collectively, the "Protected Health Information"), concerning a patient other than as permitted or required by this Agreement or otherwise authorized under HIPAA.

10. The provisions of, and obligations arising under, this Agreement shall extend to, be binding upon, and inure to the benefit of the successors and assigns of each party.

11. If any part of this Agreement is determined to be invalid, illegal, inoperative, or contrary to law or professional ethics, the part shall be reformed, if possible, to conform to law and ethics; the remaining parts of this Agreement shall be fully effective and operative to the extent reasonably possible. If any restriction contained in this Agreement is held by any court to be unenforceable or unreasonable, a lesser restriction shall be enforced in its place and the remaining restrictions shall be enforced independently of each other.

12. Conformance with Law. Each party agrees to carry out all activities undertaken by it pursuant to this Agreement in conformance with all applicable federal, state, and local laws, rules and regulations.

13. This Agreement represents the entire and final agreement of the parties with respect to the subject matter hereof and supersedes all prior negotiations, discussions or agreements with respect to the subject matter hereof. This agreement may not be amended or modified except by written instrument signed by the

parties hereto.

14. This Agreement and any amendments may be executed in multiple originals; each counterpart shall be deemed an original, but all counterparts together shall constitute one and the same instrument.

15. Each signatory to this Agreement represents and warrants that he possesses all necessary capacity and authority to act for, sign, and bind the respective entity on whose behalf he is signing.

INSTITUTION

The Board of Regents of the University System of Georgia by and on behalf of Georgia State University

By: Risa Palm

Print Name: Risa Palm

Title: Provost

Date: 10-25-16

By: _____

Print Name: _____

Title: _____

Date: _____

FACILITY

Northside Hospital, Inc.

By: Skip Putnam

Skip Putnam
Vice President Administration and
CEO Northside Hospital Forsyth

Date: 11/10/2016

Exhibit A

AGREEMENT OF SPONSORING PHYSICIAN/SPONSORING AGENCY
(Mid-Level Practitioner Students (PA, APRN, CNM) and
Registered Nurse First Assistant Students (RNFA))

I acknowledge and agree as follows:

1. I have read and understand the terms and conditions of the Memorandum of Agreement between Northside Hospital, Inc. and _____
(insert name of school)
(the "Agreement") and this Acknowledgement.

2. I agree to supervise_____
(insert name of student)
and to be bound by and comply with, all provisions of the Agreement that apply to the Sponsoring Agency and/or Sponsoring Physician.

3. I understand that I am responsible for supervision of this student at Northside Hospital, including its affiliated medical practices and outpatient facilities. I understand that students are not permitted in any patient care area except under the direct supervision of a Sponsoring Physician or the Sponsoring Physician's Affiliated Professional. I understand that supervision of the student may not be delegated to another physician unless the physician has been identified as a Sponsoring Physician and has signed this same statement.

4. I understand that no patient is required to consent to participation or observation of his/her care by a student. I understand that I am responsible for verifying that my patients have consented to such participation.

5. I agree to comply with all Northside policies and procedures regarding the activities of students at Northside and will require the student to comply with all such policies. I understand the student's activities may be terminated at any time by the Chairman of my Department, the Chairman or Vice Chairman of the Medical Staff, the President or any Vice President of Northside Hospital if such termination is determined to be in the best interests of patient care at Northside Hospital.

6. If I am signing this Acknowledgment on behalf of a Sponsoring Agency, I represent that I am authorized to sign on behalf of the Sponsoring Agency.

The terms of this Acknowledgement shall survive the termination or expiration of the Agreement.

This Acknowledgement is being executed by the undersigned as of the date of execution of the Agreement and shall be effective for all purposes on and after such date.

SPONSORING AGENCY/SPONSORING PHYSICIAN

_____
Signature

Print Name:_____

Date: _____

EXHIBIT B

Student and Faculty Health History Questionnaire

NORTHSIDE HOSPITAL
Atlanta · Cherokee · Forsyth

NORTHSIDE HOSPITAL HEALTH HISTORY FORM INSTRUCTIONS Atlanta · Cherokee · Forsyth

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 <u>one</u> of the following as proof of immunization:
  1. Personal immunization record
  2. School medical records

Tuberculosis Skin Test/TST (PPD):

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

- **<u>Positive TST (PPD) Skin Test Requirements:</u>**
  To be assigned to a unit/department, you must meet **<u>ONE</u>** 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
- 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