MEMORANDUM OF AGREEMENT BETWEEN
NORTHSIDE HOSPITAL, INC.
AND
THE BOARD OF REGENTS OF THE UNIVERSITY SYSTEM OF GEORGIA BY AND ON BEHALF OF
GEORGIA STATE UNIVERSITY

This Agreement between Northside Hospital, Inc., a Georgia non-profit corporation d/b/a Northside Hospital, Inc., hereinafter referred to as "Facility," and The Board of Regents of the University System of Georgia by and on behalf of Georgia State University, hereinafter referred to as ("Institution") sets forth the ways in which Facility and Institution will cooperate for the fulfillment of clinical education requirements of the Institution. For purposes of this Agreement, Northside Hospital, Inc. includes Northside Hospital Atlanta located at 1000 Johnson Ferry Road, N.E., Atlanta, Georgia 30342, Northside Hospital-Forsyth, located at 1200 Northside Forsyth Drive, Cumming, Georgia 30041, and Northside Hospital-Cherokee located at 201 Hospital Road, Canton, Georgia 30114, and all affiliated medical practices and/or facilities owned and/or operated, in whole or in part, by Northside Hospital, Inc.

A. PURPOSE:

1. Facility and Institution desire to cooperate in the provision of clinical experiences at Facility for students of the Institution in those programs identified in Exhibit A. Specific Programs may be added or deleted from this Memorandum of Agreement at any time by attaching a revised Exhibit A, dated and signed by both Parties.

2. 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.

3. Except as specified herein, neither party intends for this Memorandum to alter in any way their respective legal rights or their legal obligations to one another, to the students and faculty assigned to the Facility, or as to any third party. Neither party is an agent, employee or servant of the other.

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 and the Facility. The starting and ending date for each Program shall be agreed upon at least ninety (90) days before the Program commences. A written plan detailing the use of the Facility, the personnel and resources to be involved, the clinical objectives, faculty participants and level of student's academic preparation shall be submitted ninety (90) days before the Program commences to the Facility's Director of Education. Program planning shall be subject to final approval by the Facility.

2. Facility will determine the number of students that will be accommodated in a Program,

and will communicate this determination to Institution. No student will be assigned to the Facility for greater than four (4) months during any academic year without express authorization from Facility's Education Affiliation Committee.

3. All student participants must be mutually acceptable to both parties and either party may withdraw 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 either party reasonably believes that it is not in the best interest of the Program for the student to continue. Such party shall provide the other party and the student with immediate notice of the withdrawal and written reasons for the withdrawal.

4. The parties agree that they will comply with all applicable non-discrimination laws in carrying out their obligations under this Agreement.

C. FACILITY RESPONSIBILITIES:

1. The Facility will retain responsibility for the care of patients and will maintain supervision of students insofar as their presence and Program assignments affect the operation of the Facility and its care, direct and indirect, of patients.

2. The Facility will provide adequate facilities for participating students in accordance with the clinical objectives developed through cooperative planning by the Institution's faculty and the Facility's staff. The Facility will use its best efforts to make conference space and classrooms available as may be necessary for teaching and planning activities in connection with the Programs. The Facility will use reasonable efforts to cooperate with student research projects, provided that all such projects must qualify as exempt research under applicable federal regulations and institutional policies.

3. Facility staff shall, upon request, assist the Institution in the evaluation of the learning and performance of participating students. Any evaluation of students by the Facility shall relate only to general student participation in the Program, and shall in no way be construed as a certification by the Facility as to the competence of any student or a representation by the Facility of any student's ability or competence in connection with the practical implementation of any knowledge gained through the Program.

4. The Facility shall provide for the orientation of both Institution faculty and participating students to the facilities, philosophies, rules, regulations and policies of the Facility.

5. The Institution and the Facility acknowledge and agree that student or faculty participants in the Program are not employees of the Facility by reason 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.

6. Subject to the Facility's overall supervisory responsibility for client services, it may, but is

not obligated to, permit appropriately licensed faculty members to provide such patient services at the Facility as may be necessary for teaching purposes. The nature and scope of activities of Institution faculty members that may involve in any way patient care at the Facility shall be subject to the sole discretion of the Facility and to such conditions as the Facility may deem necessary in its sole discretion including, but not limited to, prior proof of professional liability insurance, licensure and certification, and compliance with all Facility rules, regulations, and policies governing clinical privileges. If Faculty participation at the Facility other than as a Supervisor for the purpose of the Program is so authorized, it must not be a substitute for adequate staffing at the Facility.

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. Prior to the commencement of a Program, the Institution will, upon request, provide responsible Facility officials with such student records as will adequately disclose the prior education and related experiences of prospective student participants.

3. The Institution will ensure that only those students who have satisfactorily completed the prerequisite didactic portion of their curriculum will be selected for participation in a Program such that the Programs at the Facility are conducted in such a manner as to enhance patient care.

4. The Institution will not assign any faculty member to the Facility in connection with the operation of the Program who is not appropriately licensed, and will keep evidence of the licensure of all assigned faculty on file with the Facility at all times.

5. 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. The Facility 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.

6. The Institution and Facility acknowledge and agree that neither party shall be responsible for any loss, injury or other damage to the person or property of any student or faculty member participating in the Program unless such loss, injury or damage results from the negligence or willful conduct of that party, its officers or employees.

7. The Institution will encourage student compliance with the Facility's rules, regulations and procedures, and use its best efforts to keep students informed as to the same and any changes therein. Specifically, the Institution will keep each participating student apprised of his or her responsibility:

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 where 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.

e. To keep in confidence all medical and health information pertaining to particular patients.

8. The Institution will require all participants at the time of enrollment in the Program to undergo an initial health screening (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. Institution will provide or require students to complete the health history questionnaire attached as Exhibit B to document the initial health screening, and upon Facility's request, provide supporting documentation for the health history. If the Student's assignment to Facility includes any dates between October 1 and March 31, the Student must provide documentation of an influenza vaccine or a medical waiver. No participant shall be permitted to carry on any activities in proximity with Facility patients if the participant 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 participants 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 or faculty member at the Facility in the course of the Program shall be at the sole expense of the individual recipient of such care; provided that nothing herein shall require the Facility to provide any such care.

9. The Institution 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 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. The parties agree that i) Students shall not disclose any Protected Health Information to which a Student has access through Program participation; ii) Institution will never access or request to access any Protected

Health Information held or collected by or on behalf of the Facility; and iii) no services are being provided to the Facility by the Institution pursuant to this Agreement and therefore this Agreement does not create a "business associate" relationship.

10. The Institution will provide or require the Student to provide the credentialing records identified in Exhibit C.

11. The Institution shall have the full responsibility for the conduct of any student or faculty disciplinary proceedings and shall conduct the same in accordance with all applicable statutes, rules, regulations and case law.

E. 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 either 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 either party a meeting or conference will be promptly held between Institution and Facility 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 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 and Institution acknowledge that protection of participants in the Program from exposure to blood-borne pathogens is the joint concern of Facility, Institution and the participant. Facility will make available to participants 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 participant's Program. Facility shall provide participants with education regarding blood borne pathogens appropriate to the participant's clinical training at Facility, and, shall maintain documentation of such education.

Institution shall, to the extent required by law or regulation, offer to participants at substantial risk of directly contacting body fluids, antibody and or antigen testing and vaccination in accordance with requirements of the Occupational Health and Safety Administration and Centers for Disease Control. In the event of an exposure, to the extent required by law, Institution will be responsible for offering appropriate testing to the affected participant, providing appropriate medical care and counseling, and record-keeping. Facility will use its best efforts to appropriately test the source patient and to obtain that patient's consent to disclosure of test results to Institution.

5. The parties agree that they shall refrain from the disclosing the Student's educational records except with the Student's consent or as permitted under the Family Educational Rights and Privacy Act and Privacy Act and all regulations thereunder. Institution agrees to have the Student complete the appropriate consent forms for the exchange/disclosure of educational records and medical records reference in this Agreement.

6. Neither the Institution nor the Facility will use the other's name in any publicity or advertising material without prior written consent of the other party.

7. Unless sooner canceled as provided below, the term of this Agreement for training shall commence on October 5, 2019, and end on October 4, 2022. This Agreement may be renewed by mutual written consent of the parties. It also may be canceled at any time by either party upon not less than thirty (30) days written notice in advance of the next educational experience. Any Students in good standing participating in a clinical experience at the Facility at the time of termination shall be permitted to complete the clinical experience, and the applicable terms of this Agreement shall continue to govern their participation. Notices to a party shall be in writing and delivered to the attention of the parties below or such other designees as a party may direct.

8. This Agreement shall not be assigned or subcontracted, whether individually or by operation of law, by either party hereto without the prior written approval of the other party.

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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: INTERIM PROVOST

Date: 8/9/19

FACILITY

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

By: _____
(Signature)

Print Name: Janis Dubow

Title: VP + Chief Nursing Officer

Date: 8/30/19

EXHIBIT A

CLINICAL PROGRAMS SUBJECT TO THIS MEMORANDUM OF AGREEMENT

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

Associate of Science Degree in Nursing
Bachelor of Science in Nursing
Counseling and Psychological Services
Kinesiology & Health/Exercise Science[1]
Master of Occupational Therapy
Master of Public Administration
Master of Science in Nursing
Master of Social Work
Nutrition
Physical Therapy
Respiratory Therapy
RN to MSN Bridge Program
Speech and Audiology

This Memorandum of Agreement expires on October 4, 2022.

FACILITY

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

Title: VP + Chief Nursing Officer Date: 8/30/19

INSTITUTION

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

Title: Sr VP for Academic Affairs + Provost Date: 8/9/19

1. Northside Hospital, Inc. will accept students in this program at only the Atlanta and Forsyth locations.

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 <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[2]
- 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

2. 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.