EXHIBIT A
STATEMENT OF RESPONSIBILITY AND CONFIDENTIALITY

A. In consideration of the benefit provided to me in the form of clinical experience in the evaluation and treatment of patients of Facility, I agree to assume the risks and to be solely responsible for any injury or loss I sustain while participating in the Program operated by the School at Facility except to the extent such injury or loss is due to the negligence or willful misconduct of Facility or such injury is covered by the School's workers' compensation insurance policy pursuant to the Colorado Workers' Compensation Act, C.R.S. §§ 8-40-101 *et seq*..

I understand that as long as I am enrolled in the Program and providing health care services at the Facility as part of my Program:

- I am not considered a licensed independent practitioner, for purposes of the Facility's Medical Staff bylaws, rules and regulations;
- I must provide Facility with a background check, drug screen report, and immunization and other health records. If I fail to do so or the check or report discloses adverse information, the Facility may remove me from its facilities.
- I am not eligible for clinical privileges or Medical Staff membership and not entitled to any of the rights, privileges or hearings or appeal rights accorded under the Medical Staff bylaws;
- I may perform only those services set forth in the training protocols of the Program, as such protocols may be limited by the Facility or Medical Staff's bylaws, rules and regulations, policies and procedures;
- I shall at all times be responsible and accountable to the Teaching Practitioner(s), and shall be under the supervision and direction of the Teaching Practitioner(s); and
- My ability to function at the Facility is subject to limitation or termination at any time at the discretion of the Facility or Medical Staff.
- I will comply with applicable Facility Policies and Procedures for employees, contracted staff and students, and Medical Staff rules and regulations, policies and procedures.

B. I hereby acknowledge my responsibility under the Federal Health Information Technology for Economic and Clinical Health Act of 2009 (the "**HITECH Act**"), and the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996, as codified at 42 U.S.C. § 1320d through d-8 ("**HIPAA**") and any current and future regulations promulgated under either the HITECH Act or HIPAA, and the Agreement between the Teaching Practitioner, School and Facility, to keep confidential any information regarding Facility patients, as well as all confidential information of Facility. I agree, under penalty of law, not to reveal to any person or persons except authorized clinical staff of Facility or Teaching Practitioner any specific information regarding any patient and further agree not to reveal to any third party any confidential information of Facility except as required by law or as authorized by Facility.

I also acknowledge that during my participation in the Program, I will have access to and become acquainted with the confidential information and trade secrets of Facility, including but not limited to information about: the Facility (including its affiliates), its trade secrets, proprietary information, arrangements with suppliers or payors, its patients, patient groups, patient lists, and their personal, medical or financial information, billing practices and procedures, business techniques and methods, strategic plans, operations and related data, technical data, records, compilations of information, processes and specifications or any other information or material which derives economic value, actual or potential, from not being generally known to other persons or is the subject of efforts that are reasonable under the circumstances to maintain its secrecy or confidentiality (collectively, the "**Confidential Information**"). I acknowledge and

agree that all Confidential Information is the property of Facility and used in the course of Facility's business, and shall be proprietary information protected under the Uniform Trade Secrets Act.

I agree to keep strictly confidential and hold in trust all Confidential Information of Facility, and shall not disclose to any third party, directly or indirectly, either during the term of my rotation at Facility or at any time thereafter, any Confidential Information, or use any Confidential Information other than in the course of participating in the clinical learning experience at Facility and fulfilling the educational requirements of the Program, without the express prior written consent of Facility.

I agree that all files, records, documents, drawings, specifications, computer software, memoranda, notes, or other documents relating to the business of Facility or its Confidential Information, whether prepared by me or otherwise coming into my possession, shall be the exclusive property of the Facility and without the prior written consent of Facility, shall not be removed from Facility's premises or retained by me after conclusion of my rotation at Facility.

Dated this _____ day of _____, 201__.

By:_____
Program Participant

If applicable, I hold a physician training license, # _____, issued by the State of _____.

School: _____

Dates of Rotation: _____

Teaching Practitioner Name: _____

HealthONE LEADING HOSPITALS. TRUSTED CARE.

Clinical Access Authorization Form

ALL FIELDS WITH AN * ARE REQUIRED

FAX to: 1-866-634-8489

*Last Name:	*First Name:	MI:

*Office / Work Name and Address:	Office / Work Phone: | Ext:
Office / Work E-mail Address:	*Home Address (including City, State, and Zip Code:

*Date of Birth: (required)	*Personal Phone Number:	*Personal E-mail Address:

***Access Requested:**

Please Check any that apply:

- ☐ Meditech
- ☐ Portal (web based Meditech)
- ☐ PACs
- ☐ Scheduling Express
- ☐ Other

Action Requested:

- ☐ New ☐ Add
- ☐ Reactivate ☐ Change

☐ **HealthONE Credentialed Provider**

Please Check One:

- ☐ Doctor
- ☐ Allied Health Professional
  LIC#
- ☐ Office Staff of Credentialed Doctor
  - ☐ Clinical ☐ Non- Clinical

*Job Title:

*Providers/Group Name

☐ **Non-HealthONE Credentialed Provider**

Please Check One:

- ☐ Doctor
- ☐ Allied Health Professional LIC# _____
- ☐ Resident Grad Date: _____
- ☐ Intern Grad Date: _____
- ☐ Med Student End Date: _____
- ☐ Office Staff of Non-Credentialed Doctor
  - ☐ Clinical ☐ Non- Clinical

Providers/Group Name

Primary Facility (if applicable):

- ☐ North Suburban Medical Center
- ☐ Swedish Medical Center
- ☐ P/SL Medical Center
- ☐ Sky Ridge Medical Center
- ☐ Centennial Medical Plaza
- ☐ Rose Medical Center
- ☐ The Medical Center of Aurora
- ☐ Spalding Rehabilitation Hospital
- ☐ Swedish Southwest ER
- ☐ All

I understand the password for accessing the above designated application(s) is to be held in STRICT CONFIDENCE. I also understand willful disclosure of my password or any other user's password or misuse of any password will be considered grounds for termination of access and if applicable, company employment, privileges or engagement.

*User Signature:	Date:	*Physician Signature for Office Staff:
		*Physician's Printed Name

FOR SECURITY COORDINATOR/DESIGNEE ONLY

LSC / Designee Signature	Date:	Meditech ID/Mnemonic:
LSC / Designee Signature	Date:	User 3/4 ID:
LSC / Designee Signature	Date:	Physician Relations Manager Signature

Revised: 06/14/2017

Provider Confidentiality and Security Agreement

(for Students/Residents/Fellows)

I understand that the facility or business entity (the "Company") at which I have privileges or for which I work, volunteer or provide services, manages health information as part of its mission to treat patients. Further, I understand that the Company has a legal and ethical responsibility to safeguard the privacy of all patients and to protect the confidentiality of their patients' health information. Additionally, the Company must assure the confidentiality of its human resources, payroll, fiscal, research, internal reporting, strategic planning information, or any information that contains Social Security numbers, health insurance claim numbers, passwords, PINs, encryption keys, credit card or other financial account numbers (collectively, with patient identifiable health information, "Confidential Information").

In the course of my affiliation or assignment at the Company, I understand that I may come into the possession of this type of Confidential Information. I will access and use this information only when it is necessary to perform my job related duties in accordance with the Company's Privacy and Security Policies, which are available on the Company intranet (on the Security Page) and the Internet (under Ethics & Compliance). I further understand that I must sign and comply with this Agreement in order to obtain authorization for access to Confidential Information or Company provided systems.

• *General Rules*

1. I will act in accordance with the Company's Code of Conduct at all times during my relationship with the Company.
2. I understand that I should have no expectation of privacy when using Company information systems. The Company may log, access, review, and otherwise utilize information stored on or passing through its systems, including email, in order to manage systems and enforce security.
3. I understand that violation of this Agreement may result in disciplinary action, up to and including termination of employment, suspension, and loss of privileges, and/or termination of authorization to work within the Company, in accordance with the Company's policies.
4. I have no intention of varying the volume or value of referrals I make to the Company in exchange for Internet access service or for access to any other Company information.
5. I have not agreed, in writing or otherwise, to accept Internet access in exchange for the referral to the Company of any patients or other business.
6. I understand that the Company may decide at any time without notice to no longer provide access to any systems to physicians on the medical staff unless other contracts or agreements state otherwise. I understand that if I am no longer a member of the Company's medical staff, I may no longer use the Company's equipment to access the Internet.

• *Protecting Confidential Information*

1. I will not disclose or discuss any Confidential Information with others, including friends or family, who do not have a need to know it. I will not take media or documents containing Confidential Information home with me unless specifically authorized to do so as part of my job.
2. I will not publish or disclose any Confidential Information to others using personal email, or to any Internet sites, or through Internet blogs or sites such as Facebook or Twitter. I will only use such communication methods when explicitly authorized to do so in support of Company business and within the permitted uses of Confidential Information as governed by regulations such as HIPAA.
3. I will not in any way divulge, copy, release, sell, loan, alter, or destroy any Confidential Information except as properly authorized. I will only reuse or destroy media in accordance with Company Information Security Standards and Company record retention policy.
4. In the course of treating patients, I may need to orally communicate health information to or about patients. While I understand that my first priority is treating patients, I will take reasonable safeguards to protect conversations from unauthorized listeners. Such safeguards include, but are not limited to: lowering my voice or using private rooms or areas where available.
5. I will not make any unauthorized transmissions, inquiries, modifications, or purgings of Confidential Information.
6. I will not transmit Confidential Information outside the Company network unless I am specifically authorized to do so by Company personnel, or as part of my service responsibilities. If I do transmit Confidential Information outside of the Company using email or other electronic communication methods, I will ensure that the Information is encrypted according to Company Information Security Standards.

• *Following Appropriate Access*

1. I will only access or use systems or devices I am officially authorized to access, and will not demonstrate the operation or function of systems or devices to unauthorized individuals.
2. I will only access software systems to review patient records or Company information when I have a business need to know, as well as any necessary consent. By accessing a patient's record or Company information, I am affirmatively representing to the Company at the time of each access that I have the requisite business need to know and appropriate consent, and the Company may rely on that representation in granting such access to me.

- ***Using Portable Devices and Removable Media***

1. I will not copy or store Confidential Information on removable media or portable devices such as laptops, personal digital assistants (PDAs), cell phones, CDs, thumb drives, external hard drives, etc., unless specifically required to do so by my job. If I do copy or store Confidential Information on removable media, I will encrypt the information while it is on the media according to Company Information Security Standards
2. I understand that any mobile device (Smart phone, PDA, etc.) that synchronizes company data (*e.g.*, Company email) may contain Confidential Information and as a result, must be protected. Because of this, I understand and agree that the Company has the right to:
    a. Require the use of only encryption capable devices.
    b. Prohibit data synchronization to devices that are not encryption capable or do not support the required security controls.
    c. Implement encryption and apply other necessary security controls (such as an access PIN and automatic locking) on any mobile device that synchronizes company data regardless of it being a Company or personally owned device.
    d. Remotely "wipe" any synchronized device that: has been lost, stolen or belongs to a terminated employee or affiliated partner.
    e. Restrict access to any mobile application that poses a security risk to the Company network.

- ***Doing My Part- Personal Security***

1. I understand that I will be assigned a unique identifier *(e.g.,* 3-4 User ID) to track my access and use of Confidential Information and that the identifier is associated with my personal data provided as part of the initial and/or periodic credentialing and/or employment verification processes
2. I will:
    a. Use only my officially assigned User-ID and password (and/or token *(e.g.,* SecurID card)).
    b. Use only approved licensed software.
    c. Use a device with virus protection software.
3. I will never:
    a. Disclose passwords, PINs, or access codes.
    b. Use tools or techniques to break/exploit security measures.
    c. Connect unauthorized systems or devices to the Company network.
4. I will practice good workstation security measures such as locking up diskettes when not in use, using screen savers with activated passwords, and positioning screens away from public view.
5. I will immediately notify my manager, Company Information Security Official (FISO), Director of Information Security Operations (DISO), or Company or Corporate Client Support Services (CSS) help desk if:
    a. my password has been seen, disclosed, or otherwise compromised
    b. media with Confidential Information stored on it has been lost or stolen;
    c. I suspect a virus infection on any system;

d. I am aware of any activity that violates this agreement, privacy and security policies; or
e. I am aware of any other incident that could possibly have any adverse impact on Confidential Information or Company systems.

- ***Upon Termination***

1. I agree that my obligations under this Agreement will continue after termination of my privileges, employment, assignment, or the cessation of my other relationship with the Company.
2. Upon termination, I will immediately return any documents or media containing Confidential Information to the Company.
3. I understand that I have no right to any ownership interest in any Confidential Information accessed or created by me during and in the scope of my relationship with the Company.

By signing this document, I acknowledge that I have read this Agreement and I agree to comply with all the terms and conditions stated above.

Provider Signature Date	Facility COID
Provider Printed Name	Company Name Rose Medical Center

HCA CONTINENTAL DIVISION
HEALTH INFORMATION MANAGEMENT SERVICES DEPARTMENT

NOTICE OF PARTICIPATION
ELECTRONIC SIGNATURE PROGRAM

I,_____, wish to participate in the Electronic
(Name of Physician)

Signature Program to authenticate medical record reports and/or orders. The reports/orders will be electronically signed via the Horizon Patient Folder (HPF) System utilized at the HCA Continental Division.

I understand that the unique identifier (PIN) assigned to me for purposes of electronic signature is official and confidential. I certify that I will not disclose the identifier assigned to me to any other person or permit another person to use it.

In the event I misuse the electronic signature option, I understand that the violation will be reported to the Medical Executive Committee and that my PIN may be inactivated to include termination of access. Misuse as defined by HCFA is "that the physician has allowed another person or persons to use his/her personally assigned identifier"

I understand that participation in the Electronic Signature Program is voluntary and that I may withdraw at any time upon written notice.

I understand the importance of signing documents on a routine basis (at least once a week) and that signature delinquencies may cause me to be removed from this program.

I understand that I am responsible for the content of all medical record entries signed electronically. I agree to review each entry or document on-line prior to affixing my electronic signature.

I agree to sign the Confidentiality Agreement to use the Horizon Patient Folder System.

_____ _____
Physician Signature Date

_____
Print Physician Name

EXHIBIT B
CONSENT TO AND RELEASE OF BACKGROUND CHECK REPORTS

In connection with my application for training or continued training at the facilities operated by HCA-HealthONE LLC d/b/a Rose Medical Center ("Facility"), I understand that a "credit report", "consumer credit report" and/or "investigative consumer report" (collectively "Background Check Reports") on me must be prepared in accordance with the requirements of the Fair Credit Reporting Act. I hereby authorize _____ ("School") to order such Background Check Reports on me, or in the event that School does not order such Background Check Reports, then I personally agree to order the Background Check Reports at my expense through a vendor approved by Facility.

I understand that these Background Check Reports may include 1) Credit Report, 2) Criminal and Civil Search (i.e., criminal or driving records, etc.), 3) Civil Search, 4) Violent Sexual Offender & Predatory Registry Search, 5) Social Security Number verification, 6) Medicare/Medicaid Integrity Check, 7) Specially Designated Nationals registry check, 8) Positive Identification (SS Death Index), 9) Prior employment verifications, and 10) Education and Licensure verifications. These Background Check Reports may also include information as to my character, work habits, performance and experience, along with reasons for termination of past employment from previous employers. Further, I understand that information may be sought from various Federal, State, and other agencies which maintain records concerning my past activities relating to my educational/school records, driving, credit, criminal, civil and other experiences, as well as claims involving me in the files of insurance companies.

I understand that, to the extent allowed by law, information contained in my enrollment or other applications to the School, Facility, or otherwise disclosed by me to such parties, may be utilized for the purpose of obtaining Background Check Reports.

I authorize, without reservation, any party or agency contacted by the vendor retained by the School or myself to conduct such Background Check Reports (the "Background Check Vendor"), to furnish the information mentioned above to the Background Check Vendor. I further authorize, without reservation, that a copy of my Background Check Reports be provided to the School and Facility, if so requested by them.

I acknowledge receipt of a copy of the summary of my rights with regard to Background Check Reports prepared by the Federal Trade Commission, entitled a "Summary of Your Rights Under the Fair Credit Reporting Act" I acknowledge that revisions of this summary may be found on the following website:
http://www.ftc.gov/bcp/conline/pubs/credit/fcrasummary.pdf.

I have read the foregoing Consent and Release and understand my rights. The authorizations granted herein shall expire the later of one year from the date noted below, or my termination in the participation in the Program. A photocopy or fax of this Consent and Release shall have the same binding effect as an original.

Program Participant's Signature _____ Date _____
Program Participant's Name Printed: _____

A "Consumer Report" may consist of employment records, education and licensure verification, driving record, previous address and public records relative to criminal charges.
An "Investigative Consumer Report" means a Consumer Report or portion thereof in which information on a consumer's character, general reputation, personal characteristics, or mode of living is obtained through personal interviews with persons having knowledge.

EXHIBIT C

CONSENT TO RELEASE OF HEALTH INFORMATION

I,_____(Program Participant) hereby consent to the release of the documents listed below from my file or records held by _____ (school) to HCA-HealthONE LLC d/b/a Rose Medical Center for the purposes of demonstrating my qualifications to participate in clinical rotations at Rose Medical Center.

Drug Screen Test Results
Immunization records
TB Tests

Signed: _____

Name: _____
(printed)

Date: _____

EXHIBIT D
CONFIRMATION OF INSURANCE

Program Participant Name (please print):_____
School (please print):

Program Participants applying to clinical rotations at HCA-HealthONE LLC d/b/a Rose Medical Center ("**Facility**") are required to have general, professional liability and/or medical malpractice insurance (as appropriate for the rotation involved) and insurance for any illness or injuries sustained while participating in clinical programs on Facility premises.

Indicate the following for the Program Participant:

1. **General, Professional Liability or Medical Malpractice coverage.** (Please check the appropriate response.)

_____ A. Our policy has been renewed for the 2013-14 academic year. The above-named Program Participant will be covered for a minimum of $1,000,000 in insurance under our policy.

Effective dates of renewed policy: _____

Name of insurance company: _____

Type of Insurance Coverage: _____

Policy Number: _____

Amount of coverage: _____

_____ B. Since our malpractice policy is not yet in place for the 2013-14 academic year, our School will indemnify and hold Facility harmless for any claims arising from the actions of the above-named Program Participant.

_____ C. We are self- insured.

2. **Health Insurance coverage**. (Please check the appropriate response.)

_____ A. School provides insurance covering any illness or injury to the Program Participant.

_____ B. Program Participant will provide his/her own insurance for all illness or injury experienced by the Program Participant .

On behalf of School:

Signed: _____
Name (please print): _____
Title:_____
Date: _____