

HEALTHSOUTH.

CLINICAL AFFILIATION AGREEMENT

AGREEMENT, made and entered into this 6th day of April , 2016 by and between THE SCHOOL BOARD OF SARASOTA COUNTY FLORIDA ("School") and HealthSouth Corporation, as agent for its affiliates and subsidiaries, which own and operate rehabilitation hospitals on a nationwide basis ("HealthSouth"). *(Suncoast Technical College)

RECITALS

WHEREAS, HealthSouth owns and operates a national network of rehabilitation hospitals and other healthcare facilities in various locations throughout the United States;

WHEREAS, the School offers its students a degree or certification program in the field of nursing, therapy, pharmacy or other clinical care and treatment;

WHEREAS, as part of such degree or certification program, the School desires for its students to have the ability to participate in clinical rotations in patient-care settings in HealthSouth hospitals; and

WHEREAS, both parties agree that it is to their mutual advantage for selected students of the School (the "Students") to receive clinical education experiences at a HealthSouth hospital.

WITNESSETH

NOW, THEREFORE, in consideration of the premises and the mutual promises contained herein, and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, HealthSouth and School do hereby agree as follows:

1. **Affiliation Procedure.** The HealthSouth hospital at which a Student performs his or her clinical rotation is referred to as the "Hospital." The clinical education program at a Hospital is referred to as the "Program." The Clinical Affiliations Coordinator in the Human Resources Department at HealthSouth's corporate office, located at 3660 Grandview Parkway, Suite 200, Birmingham, Alabama 35243, will act as a liaison between the School and Hospital regarding each Hospital's duties under this Agreement. If the School desires to place a Student at a Hospital to participate in a Program, the School may contact the Hospital directly or call the Clinical Affiliations Coordinator at (205) 969-4725 to obtain a Hospital's contact information. The School shall communicate directly with a Hospital to arrange the details of the Program for each Student. This Agreement includes degree programs/disciplines at School and will allow Students to participate in clinical rotations in the following areas: Nursing. Notwithstanding the foregoing, a Hospital is not obligated to accept any Student; therefore, in the event a particular Hospital is unable to accept any particular Student, Schools are encouraged to contact another Hospital or the Clinical Affiliations Coordinator for assistance in locating another Hospital. The parties understand and agree that the Programs are not exclusive and the School may place Students in hospitals owned and operated by other entities, and Hospitals may accept students from other educational institutions.

2. **Mutual Responsibilities.** (a) The schedule, content, objectives and goals of the Program will be arranged in cooperation between the President of the School or his/her designee and the Chief Executive Officer of the Hospital or his/her designee. The parties shall mutually agree on the number of Students and the length of time each Student shall spend participating in the Program at the Hospital.

(b) The School and the Hospital acknowledge and agree that HealthSouth and Hospital rules and regulations apply to Students. The rules and regulations of HealthSouth and the Hospital, including, but not limited to, HealthSouth's Drug and Alcohol Policy, shall be provided to the School by each Hospital. Notwithstanding the foregoing, no Student or employee of the School shall be considered an employee of HealthSouth or the Hospital at any time during the term of this Agreement.

(c) The School and the Hospital retain the privilege to exchange and review materials relevant to the Student's clinical education, and will comply with the Family Educational Rights and Privacy Act (FERPA) and applicable state law. Information from the Student's educational records will not be disclosed without the express written consent of the Student.

3. **School Responsibilities.** (a) The School shall ensure that the Students are assigned appropriately by evaluating Student competence and knowledge prior to the clinical experience. Only those Students who have satisfactorily completed the prerequisite portion of their curriculum will be selected for participation in the Program at the Hospital. Prior to the Students' clinical experience, the School shall provide the Hospital written verification that each Student is competent to perform basic emergency procedures, such as Cardio-Pulmonary Resuscitation. The School will retain ultimate responsibility for the education of its students.

(b) Faculty provided by the School, if any, shall be duly licensed, certified or otherwise qualified to participate in the Program. The School will provide proof of licensure, certification or other qualifications to Hospital upon request.

(c) The School shall select Students without regard to race, creed, sex, national origin, age, handicap or other prohibited basis. The School will assess or verify a Student's health prior to the clinical experience and require that each Student pass a medical examination acceptable to the Hospital prior to his or her participation in the Program, and at such times during his or her participation in the Program as required by law. Prior to the Students' clinical experience, the School shall provide written verification to the Hospital that each Student participating in the Program is free of communicable diseases, such as tuberculosis.

(d) The School shall (or require that each Student to) carry appropriate professional liability insurance for each student of at least \$1,000,000 per occurrence and \$3,000,000 in the annual aggregate and provide proof of such coverage to the Hospital. The School and HealthSouth agree that such insurance policies maintained by the School or Student shall be in full force and effect for a period of three (3) years after termination or expiration of the Student's clinical rotation at the Hospital. The School agrees that such insurance maintained by the School or Student may not be cancelled or materially changed without at least a thirty (30) day written notice to the Hospital.

(e) The School agrees that and shall inform Students that it is the Students' responsibility for arranging their: (i) transportation needed to fulfill their responsibilities at the Hospital; (ii) room

and board during their participation in the Program; and (iii) arrival and departure dates with the Hospital.

(f) The School shall advise the Student that he/she will be required to sign a Statement of Confidentiality in the form attached hereto as Exhibit A.

(g) The School shall advise the Student that he/she will be required to sign an Acknowledgement Form regarding HealthSouth's Drug and Alcohol Policy in the form attached hereto as Exhibit B.

(h) The School shall advise the Student that he/she will be required to sign a Release Statement Certification regarding certain investigative background checks in the form attached hereto as Exhibit C.

(i) The School shall advise the Student that he/she will be required to sign a Health Insurance Portability and Accountability Act (HIPAA) Student Training Documentation form regarding the confidentiality and privacy of patient protected health information in the form attached hereto as Exhibit D.

4. **Hospital Responsibilities.** (a) The Hospital shall provide all reasonable information requested by the School on a Student's work performance, and notify the School as soon as practical in advance of a clinical assignment or of any change in the Hospital's ability to take Students. The Hospital, in cooperation with the School, shall inform each Student of all relevant schedules, rules, and regulations of the Hospital, including HealthSouth's Drug and Alcohol Policy, and professional standards of practice. The Hospital shall provide each Student with a work schedule similar to that of a clinician. The Hospital shall complete and return all Student evaluations according to any reasonable schedule provided by the School.

(b) HealthSouth shall carry appropriate professional liability insurance on its employees, but not any Students or faculty provided by the School, in the amounts of at least \$1,000,000 per occurrence and \$3,000,000 in the annual aggregate and provide written evidence to the School upon reasonable request.

(c) The Hospital may provide to the Students, to the extent possible, first aid for injuries including, but not limited to, needle sticks. However, the Hospital assumes no responsibility, financial or otherwise, beyond the initial first aid, and treatment and the payment for such treatment shall be the responsibility of the individual Student.

(d) The Hospital shall provide clinical instruction to the Students and supervise the Students' clinical experience.

(e) The Hospital is responsible for assuring that the healthcare and rehabilitation services received by its patients are performed in a competent, efficient and satisfactory manner. Therefore, the Hospital has the right to perform criminal background screening and drug and alcohol tests on Students **prior** to the Students' participating in the Program and randomly during their participation in the Program, regardless of whether the Hospital has reasonable suspicion of drug and/or alcohol usage by the Students.

5. **Student Withdrawal.** A Student may be withdrawn from the Program at any time by the School or the Hospital for any of the following documented reasons:

- (a) Unprofessional or unethical behavior exhibited by the Student.
- (b) Failure by the Student to meet any necessary academic requirements.
- (c) Personal good cause including, but not limited to, medical emergencies.
- (d) Arrest for a felony or crime involving moral turpitude or theft.
- (e) Use of alcohol, drugs or other toxic or foreign agents which tend, in the Hospital's reasonable judgment, to limit or adversely affect the Student's duties and responsibilities.
- (f) Refusal to take a drug and alcohol test, or if a test proves positive for a measurable quantity of intoxicants, non-prescribed narcotics, hallucinogenic drugs, marijuana or other non-prescribed controlled substance, or any other violation of HealthSouth's Drug and Alcohol Policy.

6. **Confidential Information.** The School shall not disclose the terms of this Agreement to any person who is not a Student or a party to this Agreement, except as required by law, including Section 119.07, Florida Statutes, or as authorized by HealthSouth. Unauthorized disclosure of confidential information or of the terms of this Agreement shall be a material breach of this Agreement and shall provide HealthSouth with the option of pursuing remedies for breach, or, notwithstanding any other provision of this Agreement, immediately terminating this Agreement upon written notice to School. The School shall inform Students that they must maintain as confidential all HealthSouth information, including data and all patient records. Students should not copy or remove any HealthSouth materials or patient information from the premises. Students doing case studies must have a signed patient release form on the patient's chart. Each Student shall at all times abide by and adhere to all policies and procedures of HealthSouth with respect to the protection of individually identifiable health information or any requirements as may be applicable to the Students or the School in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) or the regulations promulgated relative thereto.

7. **Use and Protection of Intellectual Property.** HealthSouth retains all rights and interests in its name and logo and all related intellectual property, including programs and educational materials (collectively "Intellectual Property"). The School shall inform Students that all intellectual property Students create while at HealthSouth, through work, study or research and development activities, will be the property of HealthSouth. The School shall cause its Students to irrevocably transfer all of the Student's rights, title and interest in and to the intellectual property to HealthSouth if necessary. The School agrees to sign and give to HealthSouth any agreements, assurances, undertakings, acknowledgements or other documents we may reasonably require relating to the intellectual property during the Program or afterwards.

8. **Term.** The term of this Agreement shall be three years, commencing on March 21, 2016, and shall continue in effect for a period of three (3) years (the "Term"), unless earlier terminated: (i) by the parties upon mutual written consent; or (ii) by either party, with or without cause, upon at least ninety (90) days' prior written notice to the other. Students participating in a Program at the time of notice of termination shall be given the opportunity to complete their clinical rotation at the Hospital, with such completion not to exceed three (3) months. This Agreement does

not automatically renew and will expire at the end of the Term. The parties agree in good faith to negotiate a new Agreement prior to the end of the Term should it be mutually desirable to continue the relationship.

9. **Notice.** All notices hereunder by either party to the other shall be in writing, delivered personally or by overnight courier and shall be deemed to have been duly given when delivered personally or one day after delivered to the overnight courier, charges prepaid and properly addressed to the respective parties at the addresses shown following each party's signature to this Agreement.

10. **Governing Law.** This Agreement shall be interpreted, construed and enforced in accordance with the laws of the State of Florida. Notwithstanding the above, the parties expressly incorporate any requirement of federal, state or local law required to make this Agreement valid and enforceable.

11. **Binding Effect.** This Agreement shall be binding and shall inure to the benefit of the parties hereto, and their respective successors and assigns, and no Student or other party shall have any right under or by virtue of this Agreement.

12. **Consents and Approvals.** If any Student enters in a Hospital under the terms hereof, all consents and approvals required by the School shall be conclusively presumed to have been obtained and this Agreement shall be binding and enforceable against School.

13. **Authority.** The parties understand that HealthSouth is executing this Agreement solely as agent for its affiliates and subsidiaries which own or operate the hospitals providing clinical education experiences, each of which shall be considered the "Hospital" hereunder. Accordingly, this Agreement shall be deemed to be directly between the School and each Hospital providing the clinical education experiences for the School's Students. HealthSouth represents and warrants to School that it has the power and authority to execute this Agreement as agent for each Hospital.

14. **Entire Agreement.** This Agreement contains the entire agreement of the parties in connection with the subject matter hereof, and supersedes any and all prior and contemporaneous agreements between the parties, whether written or oral.

15. **Modifications.** This Agreement may not be changed orally, but may only be changed by an agreement in writing signed by both parties.

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed as of the date and year first above written.

SIGNATURE PAGE TO FOLLOW

**THE SCHOOL BOARD OF SARASOTA COUNTY,
FLORIDA**

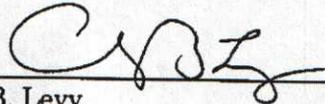
By: _____

Title: Shirley Brown
Chair

Address: _____

Approved for Legal Content
April 13, 2016 by Matthews Eastmoore,
Counsel for the School Board of Sarasota County
Signed: ASH

HEALTHSOUTH CORPORATION:

By: 

Cheryl B. Levy
Chief Human Resources Officer
Corporate Human Resources Department
3660 Grandview Parkway, Suite 200
Birmingham, Alabama 35243

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EXHIBIT A

STATEMENT OF CONFIDENTIALITY

As a participant in clinical rotations at the Hospital, I hereby acknowledge my responsibility to keep all patient and business information of the Hospital and HealthSouth confidential, in accordance with federal and state laws and regulations and the Agreement made by and between the Hospital and School. Furthermore, I agree, under penalty of law, not to disclose: (i) specific information regarding any patient to any person or persons, except to authorized clinical staff and associated personnel as necessary to perform my clinical rotation duties; and (ii) any confidential business information of the Hospital and HealthSouth to any third party. This Statement of Confidentiality shall continue in effect after my clinical rotation at the Hospital has expired or terminated.

Dated this _____ day of _____, 20__.

Name of Student (Print)

Signature of Student

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EXHIBIT B

DRUG AND ALCOHOL POLICY ACKNOWLEDGEMENT FORM (CONFIDENTIAL)

By signing below, I hereby acknowledge that I have received a copy of HealthSouth's Drug and Alcohol Policy and agree that I will read the policy.

I understand that situations may occur in which I will be required to take a drug or alcohol test or submit to a search of my person or possessions in accordance with Hospital policy. I also understand that I may be withdrawn from participation in my clinical rotation at the Hospital: (i) by refusing to take a drug or alcohol test; (ii) by refusing to allow a search; (iii) if a drug or alcohol test proves positive; or (iv) if a search discloses possession of a prohibited item, such as a weapon.

I further understand if I am involved in a work-related accident, I may be required to submit to a blood or urine test. I also understand that I may be withdrawn from participation in my clinical rotation at the Hospital: (i) by refusing to take a blood or urine test; or (ii) if such blood or urine test proves positive.

I also understand that upon my request I will be provided a list of all drugs / substances for which tests will be conducted.

I further understand that adherence to HealthSouth's Drug and Alcohol Policy is a condition of clinical rotation for all students and hereby consent to and accept such policy as a condition of my rotation.

Student Signature

Date

Student Printed Name



EXHIBIT C
RELEASE STATEMENT CERTIFICATION

I hereby authorize HealthSouth Corporation and/or its agents to make an independent investigation of my background for the purpose of confirming the information contained on my application and/or obtaining other information which may be material to my qualification for employment or participation in a clinical rotation within a Healthsouth hospital, and to conduct pre-employment or other employment related inquiries after I am hired or selected to participate in a clinical rotation at a Healthsouth Hospital (to the extent allowed by law). This investigation may access records maintained by both public and private organizations. Information requested may include, but is not limited to:

- Professional and personal references
Motor vehicle records
Criminal and police records
Public records
Education
Professional credentials
Past and current employment
Urine or blood tests to determine drug or alcohol use.

I authorize any individuals or entities contacted during this investigation to give you any and all pertinent information they may have, personal or otherwise, and release all parties from any and all liabilities, claims or law suits in regard to the information obtained.

I understand that the complete and final results of HealthSouth's investigation of my background may not be available to HealthSouth before employment, if any, with the Company commences. I also understand that the results of HealthSouth's investigation into my background may affect my employability, continuing employability or eligibility to participate in a clinical rotation within a Healthsouth hospital.

The following is my true and complete legal name and all information is true and correct to the best of my knowledge.

Signed: _____ Date: _____
(Applicant)

PLEASE PRINT THE FOLLOWING INFORMATION. FILL IN ALL BLANKS COMPLETELY:

Last Name: _____ First Name: _____ Middle Name: _____

Other names you have used in the past 5 years. (Maiden name, nickname, alias, etc.): _____

Present Address: _____

Previous: _____

Provide the following information on places you have worked or lived during the past five years:

City State From: Month/Year To: Month/Year City State From: Month/Year To: Month/Year

City State From: Month/Year To: Month/Year City State From: Month/Year To: Month/Year

Driver's License #: _____ State of License: _____ * Date of Birth: _____

Social Security Number: _____ Position Applying For: _____

If an investigative consumer report is pulled on me for employment purposes, I wish to receive a copy of the report from TransUnion Birmingham Division.

* Date of birth is used only for purposes of record identification when requesting the above mentioned reports.

FOR FACILITY USE ONLY

The following information must be completed by the Hospital in order to process this request. Please PRINT clearly

Hospital Name: _____ Phone Number: _____
Hospital Number: _____ Secured Fax Number: _____
Requested By: _____ E-mail address: _____
Job Title: _____
(Must be Supervisor or above)

o Criminal (Required for affiliation students on site for longer than two weeks.) Result: _____ Date: _____ Source: _____

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EXHIBIT D

HIPAA Student Training / Orientation

Confidentiality and Privacy mean that the patients have the right to control who will see their protected health information. With the enactment of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), a patient's right to have his/her health information kept private, secure and confidential became more than just an ethical obligation of healthcare providers; it became a federal law.

Protected Health Information (PHI) includes patient identity, address, age, social security number and any other personal information that patients are asked to provide. In addition, protected health information includes why a person is sick or in the Hospital, what treatments and medications he/she may receive, and other observations about his/her condition or past health conditions.

Healthcare providers use information about patients to determine what services they should receive. Ask yourself before looking at any protected health information:

- Do I need this in order to perform my clinical rotation duties and provide quality care?
- What is the least amount of information I need to perform my clinical rotation duties?

Depending on your task, if you do not need to know confidential patient information, then you should not have access to it.

Ways to protect a patient's privacy include:

- Keep discussions about patient care private if reasonably possible by closing doors, pulling curtains and conducting discussions so that others cannot overhear.
- Keep medical records locked and out of public areas.
- If you find that you are overhearing someone else discuss patient information, let them know they can be overheard, and politely remind the individual of the Hospital's privacy policies.
- Do not release any patient information, unless your supervisor has obtained a written authorization from the patient.
- Do not leave messages on answering machines regarding a patient's condition or test results.
- If you should need to copy medical records to complete an assignment, ask your supervisor for permission before making copies. Redact the patient's personal identifiers (i.e. name, date of birth, address, medical record number, insurance information and social security number, if captured) prior to taking the record out of the hospital. Return all copies to the hospital and shred.
- If there are persistent problems regarding breaches of confidentiality or you have any questions, notify or contact your clinical rotation supervisor at the Hospital.

As a student participating in a clinical rotation at the Hospital, I recognize the patients' right to privacy and agree to abide by the Patient's Bill of Rights as posted within the Hospital.

Additionally, I agree that information relating to a patient's physical and/or emotional status will not be released or discussed except as needed for the care of that patient.

I also understand that breaking HIPAA's rules and regulations can mean either a civil or criminal sanction (penalty).

My signature below indicates that I have read and understood the above information, and will abide by the policies and procedures of the Hospital.

Date

Student Signature

Student Name

Employee Signature

Employee Name