CLINICAL EXPERIENCE AGREEMENT

THIS AGREEMENT ("Agreement") is made on this [Date] day of [Month] 2006, by and between The Rector and Visitors of the University of Virginia, for its School of Medicine, a not-for-profit educational institution of the Commonwealth of Virginia ("Institution"), and Carilion Medical Center ("Carilion").

RECITALS

WHEREAS, the Institution, as part of its formal, educational course of studies for health care professionals may require clinical experiences of students, and desires to assign certain of its students to one or more Carilion facilities to obtain such clinical experience; and

WHEREAS, Carilion, in service to the community and to promote high standards of preparation and training for health care professionals is willing to provide the necessary facilities for a clinical experience; and

WHEREAS, Carilion and School of Medicine have entered into an Affiliation Agreement, effective November 2, 2005, which supplements the procedures for conducting the clinical experiences described herein;

NOW, THEREFORE, in consideration of the foregoing premises and mutual covenants and promises contained herein, and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties agree as follows:

1.0 Definitions.

1.1 "Affiliation Agreement" shall mean the Affiliation Agreement between Carilion Medical Center and the University of Virginia School of Medicine, attached hereto and incorporated herein as Attachment 1.

1.2 "Associate Dean-Roanoke" shall mean the individual appointed by Carilion pursuant to Section II(A) of the Affiliation Agreement.

1.3 "Clinical Experience" shall mean a structured learning experience at a Carilion Facility in which a Student participates in the care of patients under the guidance of a Preceptor and participates in observational and other educational activities appropriate to the Student's level of preparation.

1.4 "Director" shall mean the Director of the Program.

1.5 "Facility" shall mean the Carilion Medical Center in Roanoke, Virginia or other Carilion owned or affiliated facilities that Carilion designates.

1.6 "Faculty" shall mean each individual employed by or affiliated with the Institution to instruct and supervise Students as part of the Program.
1.7 "Preceptor" shall mean an individual staffed at the Facility to facilitate Student learning and to provide guidance to Students at the Facility as part of the Clinical Experience.

1.8 "Program" shall individually and collectively mean the program(s) as identified in the Affiliation Agreement.

1.9 "School Year" shall mean July 1 – June 30.

1.10 "Student" shall mean a student officially enrolled at the Institution who participates in the Program at the Facility.

2.0 Obligations of Institution. The Institution shall:

2.1 Prior to performing their duties pursuant to this Agreement, make reasonable efforts to advise Students of their obligations and responsibilities pursuant to this Agreement.

2.2 For the 2005-2006 School Year under this Agreement, Institution shall pay Carilion $151,296 (in 4 quarterly installments of $37,824) for the services of Program administration, housing and meals to assist in the instruction of the Institution's medical students. The amount payable for subsequent School Years shall be mutually agreed upon by the Parties and set forth in separate amendments to this Agreement. Institution and Carilion acknowledge and agree that the compensation provided by Institution to Carilion for the Clinical Experiences represents the fair market value for such services and that such payment to Carilion is not in consideration for patient referrals to Institution. Payments will be sent to the following address:

Carilion Medical Center  
P.O. Box 40032,  
Roanoke, VA 24022-0032

2.3 The Institution warrants that it requires each of its Students to complete the Institution's "Pre-Entrance Health Record" and "Application for Medical Student Clinical Appointment" forms, attached hereto as Exhibit A, and Institution agrees to assign to Faculty only those Students who satisfy Institution's requirements for eligibility for clinical appointments.

3.0 Obligations of Carilion. Carilion shall:

3.1 Provide secretarial support and office space, utilities and office supplies for the Associate Dean-Roanoke. The secretary shall be the employee of Carilion and Carilion shall provide all worker’s compensation requirements and waive subrogation rights against the Institution.

3.2 Provide the services of a medical student coordinator to assist with the implementation of the Program. The coordinator shall be the employee of Carilion and Carilion
shall provide all workers' compensation requirements and waive subrogation rights against the Institution.

3.3 Provide the Institution's Students assigned to the Facility with appropriate housing and meals. The Institution shall not be responsible for any damages or liabilities arising out of the housing or meals provided by the Facility to the Students.

3.4 Nothing in this Agreement shall be construed to require Carilion or the Facility to contract with any additional person(s) to meet its obligations hereunder.

4.0 Care to Patients.

4.1 Carilion shall retain responsibility for the overall care provided to patients in the Facility. Students shall at all times be under the guidance of a Preceptor while performing activities at the Facility pursuant to the terms of this Agreement. Carilion reserves the right to establish limits on the numbers and types of Students permitted in each patient care unit of the Facility and to restrict specific Student activities in each patient care unit.

4.2 Patient notes prepared by Students shall be included as a portion of the patient's record to facilitate faculty review of the Student's participation and competence. Students will not be responsible for writing or dictating discharge summaries. Students may be responsible for writing progress notes and procedure notes in addition to recording initial history and physical examinations. These notes will be countersigned by a resident or attending member of the Facility's medical staff.

5.0 No Payments. Except as provided in Section 2.2 herein, the Clinical Experience furnished to Students in connection with this Agreement is gratuitous and voluntary and shall be accomplished without any payment made by Carilion to the Institution, its Faculty, Students, employees, or agents. Carilion shall not be responsible for any income tax withholding, social security taxes, workers' compensation, and unemployment compensation with respect to Institution's Faculty, Students, employees and agents.

6.0 Insurance.

6.1 Institution, as an authorized agency of the Commonwealth of Virginia participates in the Commonwealth's self insured program, as provided in the Code of Virginia, which provides general liability coverage to it's agencies, institutions, employees, and agents, and students to the extent students are authorized by the University to participate in supervised clinical practica, for acts or omissions arising out of and in the course of their employment and authorization. Institution is precluded by law to indemnify or save harmless third parties. Claims made against the Commonwealth of Virginia, its agencies or institutions are subject to a maximum amount of $100,000 per claim. Claims made against its employees or agents are subject to a maximum amount of $2 million per claim. Claims made against employees or agents arising out of a medical incident are subject to a maximum amount provided in Section 8.01-581.15 of the Code of Virginia (presently set at $1,800,000 per medical incident). Statutory limits prevail for Workers' Compensation liability.
6.2 Notwithstanding Section III(D) of the Affiliation Agreement, Carilion agrees that Institution shall not be required to provide Carilion with notice of changes to or cancellation of its coverages under the state self insured program. To the extent that Section III(D) of the Affiliation Agreement requires such notice, this Section 6.2 explicitly supersedes Section III(D) and removes such notice obligation from the Affiliation Agreement.

6.3 To the extent permitted under applicable law, Carilion will be responsible for the negligent acts or omissions of its agents and employees. Carilion will maintain at its sole expense adequate medical malpractice and general liability insurance or self-insurance coverage to satisfy its obligations under this Agreement, and such general liability insurance will provide for a minimum limit of $1,000,000 per occurrence, whereas the medical malpractice insurance shall equal or exceed the medical malpractice limit per Section 8.01-581.15 of the Code of Virginia (presently set at $1,800,000) with an aggregate limit of not less than $3,000,000.

7.0 Right to Refuse or Terminate Students. Carilion reserves the right to refuse acceptance of any Student designated by the Institution for participation in a Clinical Experience and to terminate participation by any Student in a Clinical Experience when, in the sole opinion of the Carilion: (i) the Student is deemed to be a risk to the Facility’s patients, employees, or to himself or herself, (ii) the Student fails to meet or abide by the rules, regulations, policies and procedures of the Facility, (iii) the Student’s conduct is detrimental to the business or reputation of the Facility or Carilion, (iv) the Student fails to accept or comply with the direction of Facility staff, or (v) further participation by the Student would be inappropriate.

8.0 Independent Contractors/No Agency. In the performance of duties and obligations hereunder, no Faculty, Student, employee, or agent of the Institution shall, for any purpose, be deemed to be an agent, servant or employee of Carilion. No employee or agent of Carilion shall be authorized to act for or on behalf of the Institution. Neither party shall withhold on behalf of the employees of the other, any sums for income tax, unemployment insurance, social security or any other withholding or benefit pursuant to any law or requirement of any governmental body. Nothing in this Agreement is intended nor shall be construed to create any employer/employee relationship, a joint venture relationship, or to allow the parties to exercise control over one another or the manner in which their employees or agents perform the services which are the subject of this Agreement.

9.0 Access to Records. Until the expiration of four (4) years after the furnishing of services under this Agreement, Institution shall make available to the Secretary of Health and Human Services, the U.S. Comptroller General, or any of their duly authorized representatives, this Agreement and such of the Institution’s books, documents and records as are necessary to verify the nature and extent of costs incurred by Carilion or the Institution with respect to such services for which payment may be made under Title XVIII or Title XIX of the United States Social Security Act.

10.0 Assignment. This Agreement shall not be assigned or subcontracted, whether individually or by operation of law, by either party hereto.
11.0 **Term.** The term of this Agreement shall be the 2 year period commencing July 1, 2005, through June 30, 2007. This Agreement may be renewed upon the mutual written consent of the parties.

12.0 **Termination.**

12.1 This Agreement shall run for the Term unless earlier terminated as provided herein.

12.2 This Agreement may be terminated at any time upon written mutual consent of the parties.

12.3 This Agreement may be terminated by either party without cause by giving prior written notice of not less than sixty (60) days, provided that all medical students currently assigned to the Facility at the time of notice of termination will be given the opportunity to complete their rotations at the Facility or at other locations approved by the Institution.

12.4 This Agreement shall terminate based on a material breach of this Agreement by either party, provided that the breaching party fails to cure the breach within thirty (30) days of the date of a written notice of the breach. If such breach is not cured within thirty (30) days of the notice, the date of termination shall be the thirtieth (30th) day following the date of the notice.

12.5 This Agreement shall terminate automatically on the insolvency or termination of the State Insurance Reserve Trust Fund, in the absence of any other provision for insurance conforming to the requirements of Section 6, above.

13.0 **Confidentiality.**

13.1 The parties agree that the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and regulations promulgated thereunder, including the Privacy Rule (Standards for Privacy of Individually Identifiable Health Information at 45 C.F.R. part 160 and part 164, subparts A and E), require certain protection of Protected Health Information (as defined by HIPAA and the Privacy Rule). Institution acknowledges that its Faculty and Students may have access to Facility’s Protected Health Information during its Students’ Clinical Experience. Institution shall train its participating Faculty and Students on the protection and privacy of Protected Health Information and provide Carilion with evidence of such training prior to assigning Faculty and Students to a Carilion Facility. Such training shall meet the requirements of HIPAA and the Privacy Rule. Nothing in this Section 13.2 shall be construed as diminishing or eliminating Carilion’s obligation to orient Students to its facility-specific policies and procedures in accordance with Section II J of the Affiliation Agreement.

13.2 This Confidentiality Section shall survive termination of this Agreement.
14.0 **Notice.** All notices under this Agreement shall be in writing and delivered by hand or deposited, postage prepaid, in first-class U.S. mail, registered and return receipt requested, addressed as follows or to such other address as a party may designate in writing accordance with this Section:

**If to Carilion:**
Nancy Agee  
Carilion Medical Center  
P.O. Box 40032,  
Roanoke, VA 24022-0032

**With a Copy to:**
Daniel Harrington, MD  
Carilion Medical Center  
P.O. Box 40032,  
Roanoke, VA 24022-0032

**If to Institution:**
Stephen A. Kimata  
Assistant Vice President for Finance & University Comptroller  
University of Virginia  
1001 North Emmett Street  
Charlottesville, VA 22904-4195

**With a copy to:**
Jay Scott  
Senior Associate Dean for Finance and Administration  
University of Virginia School of Medicine  
P.O. Box 800793  
Charlottesville, VA 22908-0793

15.0 **Entire Agreement.** This Agreement supersedes all earlier agreements between the parties and contains the final and entire Agreement between the parties with respect to the subject matter hereof and they shall not be bound by any terms, conditions, statements, or representations, oral or written, not herein contained, unless contained in a written executed amendment of this Agreement signed by all parties.

16.0 **Severability.** Should any provision(s) of this Agreement be held invalid, unlawful or unenforceable, the validity of any other provision(s) of this Agreement or the Agreement as a whole shall not be affected.

17.0 **Governing Law.** This Agreement shall be construed under and enforced in accordance with the laws of the Commonwealth of Virginia (excluding her choice of law provisions), and it shall be construed in a manner so as to conform with all applicable federal, state and local laws and regulations.
18.0 Compliance with Applicable Laws.

18.1 The parties agree to comply with applicable laws, regulations, rulings, and standards and amendments thereto, of all entities which regulate, license, govern and/or accredit the parties, including, but not limited to, federal, state and local governmental agencies.

18.2 In the event there are changes to or clarifications of federal, state or local statutes, regulations or rules which would materially affect the operations of the Facility or Carilion, including, but not limited to, third-party reimbursement or Carilion’s tax-exempt status, the parties agree to examine this Agreement and to renegotiate any applicable provisions to accommodate the changes in the law.

19.0 Counterparts. This Agreement may be executed in two or more counterparts, each of which shall be deemed an original but all of which together shall constitute one and the same instrument.

20.0 Headings. Headings used in this Agreement are solely for the convenience of the parties and shall be given no effect in the construction or interpretation of this Agreement.

21.0 Waiver. No waiver of any breach of this Agreement shall constitute or be deemed a waiver of any other or subsequent breach. All remedies afforded in this Agreement shall be taken and construed as cumulative to every other remedy provided hereby or at law.

22.0 No Third Party Beneficiaries. This Agreement is not intended to and shall not confer upon any other person or business entity, other than the parties hereto, any rights or remedies with respect to the subject matter of this Agreement.

[Remainder of page intentionally blank]
IN WITNESS WHEREOF, and in agreement hereto, Carilion and the Institution have caused this Agreement to be executed in their respective behalf by their authorized representatives.

CARILION

Nancy Howell Agee
COO Carilion Medical Center

[Signature]

5/15/04
Date

Daniel Harrington, M.D.
Director of Medical Education
and Associate Dean of Roanoke

[Signature]

5/15/04
Date

INSTITUTION

Stephen A. Kimata
Assistant Vice President for Finance & University Comptroller

[Signature]

[Date]

Arthur Garson, Jr., M.D., MPH
Dean, School of Medicine

[Signature]

[Date]
ATTACHMENT 1

Affiliation Agreement Between Carilion Medical Center and the University of Virginia School of Medicine
ATTACHMENT A

UNIVERSITY OF VIRGINIA
PRE-ENCERANCE HEALTH RECORD
Department of Student Health
P.O. Box 800760
Charlottesville, Virginia 22908-0760
(434) 924-1525
Website: http://www.virginia.edu/studenthealth/

FORM IS DUE TO STUDENT HEALTH
BY AUGUST 1, 2006 FOR FALL
ENCERANCE OR MARCH 31, 2006
FOR SPRING ENCRANCE

TO THE STUDENT: Please type or print in black ink, answering all questions. This information will become part of your confidential medical record. Please attach a separate sheet if you need extra space to answer any questions. FAX: 434-862-4252.

Name ____________________________________________________________________________ Social Security No. __________________________

Last: ___________ First: ___________ Middle: ___________ Date of Birth: _______/_______/_______

Address ____________________________________________________________________________

No. & Street ________________________________________________________________________ City: ___________ State: ___________ Zip: ___________

Telephone ( ) ________________ Circle Sex: M F Birthday: _______/_______/_______

Mo. Day Year

UVa School you are entering: __________________________________________________________

Check one: Undergraduate ☐ Graduate ☐ Circle Term entering: Fall ☐ Spring ☐ 20___

☐ Check here if you have previously enrolled in UVa and give dates: from ___________ to ___________

Mo/Year Mo/Year

PARENT/GUARDIAN/NEXT-OF-KIN/SPOUCE INFORMATION (for contact in case of emergency)

Name __________________________________________ Relationship to student: ________________________

Last: ___________ First: ___________ Middle: ___________

Address ____________________________________________________________________________

No. & Street ________________________________________________________________________ City: ___________ State: ___________ Zip: ___________

Telephone ( ) ________________

PRIMARY CARE PHYSICIAN NAME AND PHONE NUMBER: _____________________________

HEALTH INSURANCE IS A REQUIREMENT FOR ALL UNIVERSITY OF VIRGINIA STUDENTS.
(Registration for subsequent semesters will be blocked if information not provided)

Enter either the name of your health insurance carrier OR your parent's health insurance carrier if you are covered as a dependent:

__________________________________________________________________________________________

Student Insurance Carrier ____________________________________________________________________

Parent's Insurance Carrier ____________________________________________________________________

ATTACH A COPY OF YOUR INSURANCE CARD, FRONT AND BACK, AND YOUR PRESCRIPTION CARD, IF SEPARATE, TO THIS FORM. Whenever visiting Student Health or other care provider, have your insurance card(s) with you.

If you will purchase the CHICKERING HEALTH INSURANCE PLAN endorsed by the University of Virginia, indicate by checking the box below. Chickering's phone number is 800-488-3027 or visit the website, www.chickering.com.

☐ I WILL PURCHASE THE CHICKERING STUDENT HEALTH PLAN

☐ Yes

LONG TERM SIGNATURE AGREEMENT

(Last) ____________________________________________________________________________ (First)________________________ (Middle)_________________________

I hereby assign the benefits of my insurance policy to the University of Virginia Student Health Department and University of Virginia Health System, as appropriate. I understand that I am responsible for all charges that are not paid by that policy. I authorize Student Health to release to my insurance company information needed in order to obtain pre-authorization for treatment or process a claim for services rendered.

I understand that this assignment and authorization will remain in effect indefinitely or until such time that I give written notice to the contrary.

Date ___________ Signature __________________________________________________________________
PART B: Tuberculosis Screening
(Required of all students)

Name: __________________________ Date of Birth: __________ Social Security No: ______________________

TO BE COMPLETED BY YOUR HEALTH CARE PROVIDER

Based on the guidelines published by The American College Health Association, the recommendations from the Centers for Disease Control (CDC) and the American Thoracic Society, Tuberculosis Screening is required within six months of college entry primarily by conducting a Risk Assessment. For more information, visit www.tcb-site.org or refer to the CDC’s Core Curriculum on Tuberculosis available at state health departments or at the following website: www.cdc.gov/campaign/tb/outreach/consent/. Please answer the following questions. If the student is at low risk, a PPD is not required for entrance into college.

1. Does the student have signs or symptoms of active TB disease? □ YES □ NO
   If NO, proceed to question 2.
   If YES, proceed with additional evaluation to exclude active TB disease including tuberculin skin testing, chest x-ray and sputum evaluation as indicated.

2. Is the student a member of a high-risk group or is the student entering the Health Profession? □ YES □ NO
   Categories of high-risk students include those with HIV infection; who inject drugs; who have resided in, volunteered in or worked in high-risk congregate settings such as prisons, nursing homes, hospitals, residential facilities for patients with AIDS, or homeless shelters; and those who have clinical conditions such as diabetes, chronic renal failure, leukemias or lymphomas, low body weight, gastrectomy and jejunal bypass, chronic malabsorption syndromes, prolonged corticosteroid therapy (e.g. prednisone ≥ 15 mg/d for ≥ 1 month) or other immunosuppressive disorders.
   If NO, continue to question 3.

   If YES, place tuberculin skin test (Mantoux only; Inject 0.1 ml of purified Protein derivative [PPD] tuberculin containing 5 tuberculin units [TU]) intradermally into the volar (inner) surface of the forearm. A history of BCG vaccination should not preclude testing of a member of a high-risk Group. If PPD is not placed, a chest x-ray is required (see B to record x-ray result).

3. Has the student lived or travelled (spent 6 weeks or more) in countries where TB is endemic? □ YES □ NO
   Includes students who have arrived within the past 5 years from countries other than those on the following list: Canada, Jamaica, Saint Kitts and Nevis, Saint Lucia (USA), Virgin Islands (USA), Belgium, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Liechtenstein, Luxembourg, Malta, Monaco, Netherlands, Norway, San Marino, Sweden, Switzerland, United Kingdom, American Samoa, Australia, or New Zealand.
   If NO to #1, #2 & #3, PPD and Chest X-Ray are not required. No further evaluation is required, please sign below.
   If YES, Students should undergo tuberculin skin test or Chest X-ray. (See #2 Above)

PLEASE USE THE SPACE BELOW TO DOCUMENT TUBERCULIN SKIN TESTING AND/OR CHEST RADIOGRAPHY* *(Based on assessment criteria outlined above)

A. Tuberculin Skin Test (must have been administered or on or after March 1, 2005)
   Date given: __________ Date read: __________ Result: __________ mm
   (Record actual mm of induration, transverse diameter; if no induration, write "0")
   Interpretation (based on mm of induration as well as risk factors): □ Positive □ Negative

B. Chest X-Ray (required if Tuberculin Skin test is positive or if PPD has not been placed but patient is at risk of disease; must have been performed on or after March 1, 2005)
   Result: □ Normal □ Abnormal Date of chest x-ray: __________
   INH Initiated or Data: __________ X __________ months

HEALTH CARE PROVIDER: (signature required as validation of correct information for TB assessment only)

Name: __________________________ Address: __________________________

Signature: __________________________ Phone: __________________________ Date: __________________________

(TB screening must be performed on or after March 1, 2005)
IMMUNIZATION RECORD

Name: ________________________  Last: ________________________  First: ________________________  Middle: ________________________

Date of Birth: ____________  Social Security Number: ____________

Part A: REQUIRED AND SIGNED BY YOUR HEALTH CARE PROVIDER. Enter all information in English.

I. REQUIRED FOR ALL STUDENTS (*if born 1956 or before, only starred items required*)

Registration for Spring Semester will be blocked if all available immunizations are not up to date

A. TETANUS-DIPHTHERIA

Tetanus-Diphtheria booster must be within the last ten years

B. MM(R) (MEASLES, MUMPS, RUBEOLA)

Two doses required, at least one month apart

Dose #1  ____________  Dose #2  ____________

OR ALL 3 OF THE FOLLOWING CRITERIA ARE MET:

MEASLES (RUBEOLA)

Has report of positive immune titer: Specify date: ____________

Or two doses of individual rubeola vaccine

Dose #1  ____________  Dose #2  ____________

RUBEOLA (GERMAN MEASLES)

Has report of positive immune titer: Specify date: ____________

Or two doses of individual rubeola vaccine

Dose #1  ____________  Dose #2  ____________

MUMPS

Has report of positive immune titer: Specify date: ____________

Or two doses of individual mumps vaccine

Dose #1  ____________  Dose #2  ____________

C. POLIO

Has report of positive immune titer: Specify date: ____________

Or Primary Series: Yes ☐  No ☐  Last Booster: Date: ____________

D. HEPATITIS B (Undergraduates only)

Has report of positive immune titer: Specify date: ____________

OR

Hepatitis B Vaccination

Dose #1  ____________  Dose #2  ____________  Dose #3  ____________

Twinside (Combination A & B)

Dose #1  ____________  Dose #2  ____________  Dose #3  ____________

OR  ☐ Waiver  ☐ Not undergraduate


E. MENINGOCOCCAL MENINGITIS: (Undergraduates Only) One of 3 criteria must be met.

(One dose of conjugate vaccine preferred. Polysaccharide acceptable alternative in last 2 years.)

Vaccination Date: ____________  ☐ Menactra (conjugate)  ☐ Meningite (polysaccharide)  ☐ Waiver  ☐ Not undergraduate


II. RECOMMENDED VACCINATIONS

Based on American College Health Association (ACHA) and the CDC guidelines, the following immunization is recommended, not required, and offered by Student Health. Consult your personal physician or Student Health if you have questions.

A. VARICELLA (chicken pox): Two doses one month apart for adults with no history of disease: Dose #1  ____________  Dose #2  ____________

III. OTHER IMMUNIZATIONS RECEIVED:

Hepatitis A (if Twinside, see section I.D. above): Dose #1  ____________  Dose #2  ____________  Other (specify): ____________

IV. SPECIAL REQUIREMENTS FOR MEDICAL AND NURSING STUDENTS

A. You MUST have a rubella antibody titer test done if born in 1957 or later. The titer must prove immunity.

Date drawn: ____________  Results: Immune ☐  Non-immune ☐

B. Have you had varicella (chicken pox)? Yes ☐  No ☐  If no, a varicella antibody blood test is required, even if you have had the varicella vaccine. The titer must prove immunity.

Date drawn: ____________  Results: Immune ☐  Non-immune ☐

C. HEPATITIS B (series of 3 vaccinations or antibody test): EITHER vaccinations OR antibody test REQUIRED:

1. Hepatitis B Vaccination

Dose #1  ____________  Dose #2  ____________  Dose #3  ____________

Twinside (Combination A & B)

Dose #1  ____________  Dose #2  ____________  Dose #3  ____________

OR

2. Hepatitis B surface antibody

Date  ____________  Result: Immune ☐  Non-immune ☐

HEALTH CARE PROVIDER: Signature required as validation of correct immunization information.

(Name)  (Signature)  (Date)

Continue on to Part B for Tuberculosis Screening (Required for all students)  This requires a visit to your physician.
MEDICAL CONSENT FORM FOR MINORS

Dear Parent or Legal Guardian:

The purpose of this consent form is to obtain permission from the parent or legal guardian for the University of Virginia Health System and/or the University of Virginia Student Health Department to treat a patient who is under the age of 18 and therefore legally a minor.

The University of Virginia Health System and/or the University of Virginia Student Health Department have my permission to treat my minor child (name of child) in the event of a medical emergency. The UVA Hospital Health System and the Student Health Department also have my permission to treat my child for minor injuries and minor illness (including administration of vaccinations such as tetanus, influenza, and/or meningitis).

Name of Parent/Guardian of Minor (print) ________________________________ Relationship ________________________________

Signature ________________________________ Date ________________

Street Address ________________________________ Home Phone ________________________________

City, State, Zip ________________________________ Work Phone ________________________________

EXEMPTIONS TO PRE-ENTRANCE HEALTH IMMUNIZATIONS REQUIREMENTS
(Sec. 23-7.6 Code of Virginia)

MEDICAL EXEMPTION (PHYSICIAN’S SIGNATURE REQUIRED):

(Print Name of Student) ________________________________ should be exempt from some or all of the pre-entrance immunization requirements noted on the University of Virginia Pre-Entrance Health Record. Administration of the following immunizing agents would be detrimental to this student’s health:

______________________________________________________________

(List Immunizations) ________________________________ Date ________________

Physician’s Signature ________________________________

RELIGIOUS EXEMPTION*

I, (print name) ________________________________ wish to be exempt from the immunization requirements noted on the University of Virginia Pre-Entrance Health Record because administration of immunizing agents conflicts with my religious beliefs. I release the Commonwealth of Virginia, the University of Virginia and their agents and employees from any responsibility for any impairment of my health resulting from this exemption.

Student’s Signature ________________________________ Date ________________

*Does not apply to tuberculosis (TB) skin test
UNIVERSITY OF VIRGINIA HEALTH SYSTEMS
APPLICATION FOR MEDICAL STUDENT CLINICAL APPOINTMENT

Please print or type all information.

Name ___________________________ SS# ______________________

Please respond to these questions.

<table>
<thead>
<tr>
<th>Health Status:</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Have you complied with the Department of Student Health immunization requirements?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If you answer YES to any of the following questions, you must provide a full explanation of the details on a separate sheet, including date, place, reason, and disposition of the matter, as well as other, relevant information.

<table>
<thead>
<tr>
<th>Question</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 Do you currently suffer from any physical, mental, or emotional problems which affect, or is likely to affect, your ability to perform your duties as a medical student or which may place a patient at risk?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Do you take any medication or drugs (including alcohol or any form of drug, legal or illegal) which affect, or is likely to affect your ability to perform your duties as a medical student or which may place a patient at risk?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 Have you ever been suspended, otherwise sanctioned or had civil monetary penalties levied against you by a Medicare, Medicaid, or other Federal program?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 Have you ever been convicted, entered into a plea bargain, or pled Nolo Contendere to a felony or crime of moral turpitude?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Should the answer to any of these questions change, I understand that I am under a continuing obligation to notify the Office for Student Affairs of such change or changes in writing so long as I remain a medical student.

*Please complete reverse side of form*
I hereby make application for student clinical privileges in the University of Virginia Health System. I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics, and other qualifications and for resolving any doubts about such qualifications. I fully understand that any significant mis-statements in or omissions from this application constitute cause for denial, modification, or revocation of my clinical privileges. I confirm that all information submitted by me, in this application, is true to my best knowledge and belief.

Further, should reasonable question exist regarding my physical or mental ability to perform the privileges granted, I agree to undergo a mental or physical examination if requested and, if this shows evidence of mental or physical impairment, to provide evidence that the impairment does not interfere with my professional competence.

In making this application, I understand, that in applying for student clinical privileges in the University of Virginia Health System, I agree to the release of my credentialing and privileging information by the Office for Student Affairs for such purposes where authorized by such contract and/or endorsed by the Health System in accordance with established policy. My credentialing and privileging information may be released only for the purpose of my being credentialed under an institutional contract or for credentialing by an arm of the University, unless otherwise explicitly authorized by me in writing. All reasonable efforts will be made to maintain the confidentiality of my information and to preserve any legal privilege afforded by the information.

If granted student clinical privileges. I agree, as a medical student of the University of Virginia, to abide by the established practices, procedures, and policies of the School of Medicine and the University of Virginia Health System and those of its programs, clinical departments, and other institutions to which I may be assigned. Further, I pledge to maintain an ethical practice, abiding by the ethical principles set forth by the American Medical Association, with my patient's interest at the center of the care I render to him or her.

I have Health Insurance (Y/N) ______
On my honor as a University of Virginia student,

Signature of Applicant ____________________________

Date of Application ____________________________

For students who have been re-admitted to the School of Medicine: During your absence from the University, were you arrested or charged with or convicted of or did you serve a criminal sentence for any crime, excluding minor traffic violations which did not involve bodily injury to others? No ______ Yes ______ If yes, attach your explanation to this application providing a complete and truthful account of the circumstances.