EXHIBIT A

STATEMENT OF RESPONSIBILITY

In consideration of the benefit provided to me in the form of experience in the evaluation and treatment of patient 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 the 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:

1. I am not considered a licensed independent practitioner, for purposes of the Facility’s Medical Staff Bylaws, rules and regulations.
2. I must provide Facility with a background check. If I fail to do so, or if the check discloses adverse information, the Facility may remove me from its facilities.
3. I am not eligible for clinical privileges or Medical Staff membership and not entitled to any of the rights, privileges or appeals rights accorded under the Medical Staff bylaws.
4. I may perform only those services set forth in the training protocols of the program, as such protocols may be limited by the Facility and Medical Staff bylaws, rules and regulations, policies and procedures.
5. I shall, at all times, be responsible and accountable to the Teaching Practitioner, and shall be under the supervision and direction of Teaching Practitioner; and
6. 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.

CONFIDENTIALITY STATEMENT

I hereby acknowledge my responsibility under the Federal Health Information Technology for Economic and Clinical Health Act of 2009 (the “HITECH Act”), and the Administration 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 School and Facility, to keep confidential any information regarding Facility patient. I agree, under penalty of law, not to reveal to any person or person except authorized clinical staff and associated personnel any specific information regarding any patient except as required by law or as authorized by HealthONE.

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 payers, 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 the 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 participation 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.

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

_____________________________________________________________________________________
Program Participant Printed Name

_____________________________________________________________________________________
Program Participant Signature Date

_____________________________________________________________________________________
Dates of Rotation School Training Practitioner Name
EXHIBIT B
CONRFMATION OF INSURANCE

Student Name (please print): _____________________________________________________________

School Name: University of Colorado Denver School of Medicine

Students applying to clinical rotations at Rose Ambulatory Surgical Center, L.P. d/b/a Rose Surgical 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:

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 the School:

Signed: ___________________________________________________________________________

Name (please print): _________________________________________________________________

Title: ______________________________________________________________________________

Date: ______________________________________________________________________________
CONSENT AND RELEASE TO BACKGROUND CHECK REPORTS

In connection with my application for training or continued training at the facilities operated by Rose Ambulatory Surgery Center, L.P. d/b/a Rose Surgical Center (“Facility”), I understand that a “credit report”, “consumer credit report” and/or “investigative consumer report” (collectively called “Background Check Reports”) on me must be prepared in accordance with the requirements of the Fair Credit Reporting Act. I hereby authorize University of Colorado School of Medicine (“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 HealthONE.

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 Designed 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 activities relating to my education/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 allowable by law, information contained in my enrollment or other applications to the School, HealthONE, or otherwise disclosed by me to such parties, may be utilized for the purpose of obtaining Background Check Reports.

I authorize, without reservation, any part 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, HealthONE, and Facility, if so requested by them.

I acknowledge receipt of company 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.lic.gov/bcp/eonline.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.

Student’s Signature ____________________________________________  Date ________________

A “Consumer Report” may consist of employment records, educational 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.
CONSENT TO RELEASE HEALTH INFORMATION

I, ________________________________, (Program Participant) hereby consent to the release of the documents listed below from my student file held by ___________________________ (School) to Rose Ambulatory Surgical Center, L.P. d/b/a Rose Surgical Center for the purposes of demonstrating my qualifications to participate in clinical rotations at the hospital facilities owned or managed by HCA-HealthONE.

Drug Screen Test Results
Immunization Records
TB Tests

Signed ______________________________________________

Name (printed) _______________________________________

Date________________________________________________