AFFILIATION AGREEMENT

This agreement dated XXXXXXXXX is between TEXAS STATE UNIVERSITY (TEXAS STATE), acting through its College of Health Professions, and XXXXXXXXXXX (Facility). In this agreement all clinical training, fellowships, internships, preceptorships or field experiences will be referred to as "clinical education experiences." In consideration of the mutual promises herein contained, the parties agree as follows:

1. TERM OF AGREEMENT

1.01 **Term**: This agreement is for a term of five (5) years and shall commence on XXXXXXXX and continue until XXXXXXXX.

1.02 **Early Termination**: Either party may terminate this agreement by giving the other party one year's written notice. If either party terminates this agreement before the expiration date shown in the preceding paragraph, the Facility will not be required to provide any clinical education experiences for students who enroll in a health profession major after the date of the notice of termination. However, if early termination does occur the Facility agrees to permit students already assigned for clinical education experiences at the Facility to fully complete the clinical education experience.

2. DUTIES OF THE FACILITY

2.01 **Use of Facilities**: In order that students may obtain practical clinical education experiences as a part of their educational studies at TEXAS STATE, the Facility will permit students enrolled in the College of Health Professions at TEXAS STATE to use its facilities, equipment, library, and supplies, within the guidelines and restrictions established by the Facility. The Facility retains the right to accept or reject any proposed student at any time without cause.

2.02 **Duties and Activities**: The parties' representatives will work together to determine the specific clinical education experience that TEXAS STATE students will perform. The parties may add additional health profession programs to the agreement by revising Addendum A.

2.03 **Equipment Provided by Facility**: The Facility will provide and maintain (or cause to be provided and maintained, if appropriate) such facilities, equipment and supplies, as it deems necessary for the students' performance of their clinical education experience activities under this agreement.

2.04 **Safety Equipment Provided by the Facility:** The Facility, as it deems necessary and proper, shall make available the necessary safety equipment and supplies. The Facility shall also provide orientation for the students to the Facility.

2.05 **Student Health Needs**: The Facility is not required to provide health services to TEXAS STATE students or faculty members who supervise their clinical education experiences under this agreement except in emergency situations. The student or faculty member requiring emergency care is responsible for paying the costs associated with providing such care.

2.06 **No Employer-Employee Relationship**: The TEXAS STATE students subject to this agreement will perform their clinical education activities as part of their academic requirements in the College of Health Professions at TEXAS STATE. Consequently, no compensation or payment of any kind is due such students by the Facility and there is no employer-employee relationship between the Facility and the student during the clinical education experience. Conversely, the Facility will not charge such students or TEXAS STATE any fee or other amount for the use of its facilities, equipment, library or supplies under this agreement.

2.07 **Educational Support**: The Facility has the option to support the clinical education activities of TEXAS STATE students through a financial stipend or other types of subsidies for housing, parking, or meal costs. Such support is for the purpose of supporting the clinical education and will not constitute an employer-employee relationship between the Facility and the student.

2.08 **Student Supervision**: The TEXAS STATE students completing clinical education experiences in the Facility shall be subject to supervision by the Facility's staff at all times. The supervision will follow the appropriate professional guidelines and jurisdictional regulations established for the health care profession for which the student has been assigned.

3. DUTIES OF TEXAS STATE

3.01 **Supervision**: TEXAS STATE will be responsible for assignment, evaluation, counseling and guidance of students assigned to the Facility. Each Department or Program within the College of Health Professions will provide a faculty or staff member to supervise the clinical education experiences for its students and as appropriate for that profession. The Schools, Departments and Programs, as well as a faculty representative for each are identified in Addendum A.

3.02 **Salaries of Instructors**: The salaries and expenses of regular TEXAS STATE faculty members will be paid by TEXAS STATE and there will be no employer-employee relationship between the Facility and TEXAS STATE faculty members.

3.03 **Joint Appointments**: The parties agree that employees of the Facility may hold joint appointment serving as unpaid members of TEXAS STATE faculty. Likewise, employees of TEXAS STATE may hold unpaid positions with the Facility, as permitted by Facility's policies and appropriate By-Laws. Consent of the primary employer is required prior to finalizing the joint appointment.

3.04 **Consultant Services**: TEXAS STATE faculty members may, at their option, and to the extent that it does not interfere with their duties at TEXAS STATE, provide in-service education and serve on committees of the Facility, without charge to the Facility, when requested by the Facility. The Facility may, at its own discretion, provide payment for consultative services.

3.05 **Schedules**: TEXAS STATE will provide the Facility with the appropriate schedules indicating the time period during which the students are expected to perform their clinical education experience activities at the Facility.

3.06 **Students' Records**: TEXAS STATE will maintain student records to meet accepted educational and professional accreditation standards.

3.07 **Student Assignment**: In cooperation with the Facility, TEXAS STATE will arrange for student assignments at the Facility to complete clinical education experiences required by the health care profession.

3.08 **Policies and Procedures**: TEXAS STATE will require students to abide by all policies and procedures of the College of Health Professions, the School, Department or Program for which they are completing the clinical education experience, and the Facility. The basic education for compliance with HIPAA will be the responsibility of the School, Department or Program and will be completed prior to the student's assignment to the Facility.

3.09 **Professional Liability Insurance**: TEXAS STATE provides professional liability insurance under a blanket policy in the minimum amount of $1,000,000 per claim/$5,000,000 in the aggregate to all students enrolled in a College of Health Professions major participating in clinical education experiences. This blanket policy will also cover TEXAS STATE faculty members who provide academic or clinical teaching under this agreement. TEXAS STATE will furnish a copy of this policy to the Facility upon request.

3.10 **Immunization Requirements**: TEXAS STATE will require all students participating in clinical education experiences involving patient contact or exposure to patient specimens to submit a health report to their appropriate department or program chair. A Licensed Health Care Provider must complete the health report, which will indicate completion of immunizations for mumps, measles, rubella, tetanus, diphtheria, pertussis, meningitis, a chest x-ray or TB test (PPD/QFT), varicella, the Hepatitis B vaccine series (Addendum B), and proof of annual Flu Shot/H1N1, or if required by Facility, Addendum C for nursing students. TEXAS STATE's department or program will maintain these records and furnish them to the Facility upon request. The program may be requested to provide a Health Certificate completed by a licensed health care provider (Addendum D) by the Facility.

3.11 **Infection Control Training:** TEXAS STATE agrees to provide those students who may be involved in patient care with comprehensive infection control training, including bloodborne pathogens, prior to rotation at the Facility.

3.12 **Criminal Background Check:** As of September 1, 2005, Texas State will inform students that the Facility may require criminal background checks for all students, at the student's expense.

3.13 **Drug Testing**: As of September 1, 2014, TEXAS STATE will inform students that the Facility may require drug testing for all students, at the student's expense.

3.14 **Employment Verification**: As of September 1, 2014, TEXAS STATE will inform students that the Facility may require employment verification for all students, at the student's expense.

4. INDEMNITY

4.01 **Injury to Students**: To the extent permitted by Texas law, TEXAS STATE shall hold the Facility, its officers, agents, representatives and employees harmless from liability resulting from injury or illness to students except for claims resulting from tortious conduct or gross negligence of the Facility, its officers, agents, representatives, or employees, or any person or entity not subject to TEXAS STATE's supervision or control. Notwithstanding any provision of this contract, nothing herein shall be construed as a waiver by TEXAS STATE of its constitutional, statutory or common law rights, privileges, immunities or defenses.

5. CASE RECORDS AND HISTORIES

5.01 **Property of Facility**: All case records, case histories and regular files concerning patients at the Facility or parties consulted; interviewed or cared for by the TEXAS STATE students pursuant to this agreement shall belong to and remain the property of the Facility.

5.02 **Confidentiality**: All TEXAS STATE students and faculty members will agree to maintain the confidentiality of client's records to which they might have access, in accordance with the Facility's policies.

6. MISCELLANEOUS

6.01 **Non-Discrimination**: No person shall be excluded from participation in, denied the benefits of, or be subject to discrimination under any program and activity sponsored or conducted by TEXAS STATE on any basis prohibited by applicable law, including, but not limited to, race, color, age, national origin, religion, sex, or disability.

Additionally, in their execution of this agreement, all contractors, subcontractors, their respective employees, and others acting by or through them shall comply with all federal and state policies and laws prohibiting discrimination, harassment, and sexual misconduct. Any breach of this covenant may result in termination of this agreement.

6.02 **Texas Law to Apply**: This Agreement shall be interpreted, construed, and governed according to the laws of the State of Texas.

6.03 **Only Agreement**: This Agreement constitutes the sole and only agreement of the parties hereto and supersedes any prior understanding or written or oral agreements between parties respecting the within subject matter.

EXECUTED on the day and year first above written.

_____	_____
Facility Name Address City, State, Zip	Ruth B. Welborn, Ph.D. Dean, College of Health Professions Texas State University
_____	_____
Type or Print Name	Date
_____	
Date	

Addendum A
Affiliation Agreement

The following College of Health Professions Departments/Programs or Schools are covered by the existing affiliation agreement:

Program of Clinical Laboratory Science Office #: 512.245.3500
Contacts: Program Chair or Clinical Director

Department of Communication Disorders Office #: 512.716.2624
Contacts: Department Chair or Clinical Director

Department of Health Information Management Office #: 512.245.8242
Contacts: Department Chair or Clinical Coordinator

School of Health Administration Office #: 512.245.3556
(Healthcare Administration, Health Services Research, Healthcare Human Resources, Long Term Care Administration)
Contacts: School of Health Administration Director or Internship/Residence Coordinator

School of Nursing Office#: 512-716-2978
Contacts: School of Nursing Director or Clinical Education Placement

Department of Physical Therapy Office #: 512.716.2652
Contacts: Department Chair or Director of Clinical Education

Program of Radiation Therapy Office #: 512.245.9081
Contacts: Program Chair or Clinical Coordinator

Department of Respiratory Care Office #: 512.716.2682
Contacts: Department Chair or Clinical Coordinator

Student's Name: _____TXSTATE ID#: A0_____ Date of Birth: _____

Addendum B
Texas State University
College of Health Professions
Immunizations and Tests Form

Measles/Mumps/Rubella Vaccine - One of the following is required:	
A. Two doses of measles vaccine at least 28 days apart **OR**	Administration Date #1 _____(mm/dd/yy) Administration Date #2 _____(mm/dd/yy)
B. Serologic test positive for measles antibody	Date_____(mm/dd/yy) Circle Results: Positive Negative
Varicella (Chicken Pox) - One of the following is required: **A.** Two doses of Varicella vaccine administered 4-8 weeks apart **OR**	Administration Date #1 _____(mm/dd/yy) Administration Date #2 _____(mm/dd/yy)
B. Serologic test positive for Varicella antibody	Date _____(mm/dd/yy) Circle Results: Positive Negative

Tetanus (TDAP): Tdap protects against Tetanus, Diphtheria, and Pertussis. This vaccine is to be given every ten years. (Td is not acceptable)	Date _____(mm/dd/yy)

Meningococcal Vaccine: Evidence of vaccination if student is 21 years or younger on the first day of the semester.	Date _____(mm/dd/yy)

Flu Shot Evidence of vaccination.	Date _____(mm/dd/yy)

Student's Name: _____TXSTATE ID#: A0_____ Date of Birth: _____

HEPATITIS B (HEP B) Surface Antibody (titer) - draw titer to document immunity. This should be drawn no sooner than 1-2 months after last Hep B dose received. And the titer must be drawn within 12 months of admission into the nursing program. *Titer results must be quantitative with reference ranges included in the results.*	Date titer drawn (mm/dd/yy): _____ Circle Results: Positive Negative

A titer showing non-immunity (non-reactive, negative) will require 1-3 repeat doses of Hepatitis B and a repeat titer 1-2 months after the last doses of vaccine. You may retiter 28 days after the booster/challenge dose but must continue the series until immunity is documented. *The results must be quantitative with reference ranges included.*

*If additional doses are required to obtain immunity, document the doses and dates received below:

HEPATITIS B (HEP B) Series:

The 3-dose series of the vaccine administered over a period of at least 6 months (schedule of 0, 1, 6 months). Initial vaccine is followed by the second dose in 1 month and the third dose is 5 months after the second dose. Note: Third vaccine must be at least 6 months from initial vaccine.

Dose #1__Date #1 (mm/dd/yy): _____

Dose #2__Date #2 (mm/dd/yy): _____

Dose #3__Date #3 (mm/dd/yy): _____

OR

The 2-dose series (Heplisav-B) of the vaccine requires a minimum of 4 weeks between doses. The administration record must clearly identify the Heplisav-B series was given.

Heplisav-B Dose #1__(mm/dd/yy): _____

Heplisav-B Dose #2__(mm/dd/yy): _____

Student's Name: _____TXSTATE ID#: A0_____ Date of Birth: _____

Tuberculosis (TB) Testing: **2 Options**	**First** Administration Date _____ Date Read_____Circle Results: Positive Negative _____ Second Administration Date _____ (minimum of 7 days from first administration) Date Read_____Circle Results: Positive Negative _____
A. Two Step Tuberculin Skin Test • First test with reading must be done prior to clinical assignment. • Second administration (with reading) must be 7 or more days from the first administration. **OR** **B. TB Blood test** *Use blood test if had prior positive blood test or if received BCG vaccine. Attention: Healthcare provider If a student tests positive for TB, include a synopsis of their treatment plan with this form. The following are suggested minimum requirements to be included in this plan: • Blood test (T-Spot or QuantiFERon) if the two step skin test was positive • Chest X-ray to be completed if positive blood test • Current completed Tuberculosis Assessment and Symptoms Checklist. Attach the completed checklist (with student's name and DOB) as page 3 of this form.	Circle type of test: T-Spot QuantiFERon Date (mm/dd/yy):_____Circle Results: Positive Negative Treatment plan for (Student's Name):_____ _____ _____ _____

Physician or Approved Licensed Healthcare Provider Information:	
Printed Name	
Address	
Signature of Physician or Licensed Healthcare Provider*	Date

*** Validates all information above.**

Addendum C

2022 St. David's School of Nursing – Texas State University Immunizations and Tests Form

Student Name:_____**TXST ID: A0**_____ **Date of Birth:** _____

Attention Healthcare Provider: ***Students must provide documentation of immunization history or have received the required tests or immunizations prior to admission to the nursing program.***

MEASLES/MUMPS/RUBELLA OR MMRV* VACCINE: One of the following is required:

Two doses of the MMR vaccine. Must have a minimum of 28 days between doses.

Administration Date #1 (mm/dd/yy):_____Administration Date #2 (mm/dd/yy):_____

OR

Two doses of the MMRV vaccine. Must have a minimum of 90 days between doses.

Administration Date #1 (mm/dd/yy):_____Administration Date #2 (mm/dd/yy):_____

OR

Measles/Mumps/Rubella Serologic titer. Must show positive antibodies.

Date Serologic Titer drawn (mm/dd/yy):_____ Circle Results: Positive Negative

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Those who chose the MMRV do not need a separate Varicella immunization. You DO need a serologic titer if you have not been vaccinated.

VARICELLA (Chicken Pox): One of the following is required: *(History of Chicken Pox does not meet requirement.)*

Two doses of the Varicella vaccine to be administered at least 4 – 8 weeks apart.

Administration Date #1 (mm/dd/yy):_____Administration Date #2 (mm/dd/yy):_____

OR

Varicella Serologic titer. Must show positive antibodies. ***You DO need a serologic titer if you have not been vaccinated.***

Date Serologic Titer drawn (mm/dd/yy):_____ Circle Results: Positive Negative

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TETANUS: Tdap protects against Tetanus, Diphtheria, and Pertussis. This vaccine is to be given every ten years. Note: Td is NOT acceptable.

Administration Date (mm/dd/yy):_____

Note: It is the student's responsibility to schedule the Tdap vaccine if it expires while in nursing school. Additional renewals of the Tdap immunization should be uploaded into your Clinical Student account under the BSN/MSN Tetanus (Tdap Vaccination).

Addendum C

2022 St. David's School of Nursing – Texas State University Immunizations and Tests Form

Student Name:_____**TXST ID: A0**_____ **Date of Birth:** _____

MENINGOCOCCAL VACCINE: Evidence of vaccination is required if a student is 21 years old or younger on the first day of the fall semester. Also submit proof of this vaccine to Texas State University.
Administration Date (mm/dd/yy):_____

Note: For students who are 22 years and older, the Meningococcal vaccine is not required by the St. David's School of Nursing but is recommended. Rationale: During clinical rotations in hospitals and community centers you will be exposed to a wide variety of patients including those who have Meningitis.

HEPATITIS B (HEP B) Surface Antibody (titer): A titer is required to document immunity. This should be drawn no sooner than 1-2 months after the last Hep B dose was received **-and-** the titer must be drawn within 12 months of admission into the nursing program. *The titer results must be quantitative with reference ranges included in the results.*

Date Surface Antibody Titer drawn (mm/dd/yy): _____ Circle Results: Positive Negative

A titer showing non-immunity (non-reactive, negative) will require one of the below series of the Hepatitis B vaccine and a repeat titer 1-2 months after the last dose of the vaccine. *The results must be quantitative with reference ranges included.*

If additional doses are required to obtain immunity, document the doses and dates received below:

HEPATITIS B (HEP B) Series: The 3-dose series (Engerix-B or Recombivax HB) of the vaccine is administered over a period of at least 6 months (schedule of 0,1,6 months). The initial vaccine is followed by the 2nd dose in 1-month and the third dose is to be administered 5 months after the 2nd dose. Note: The third dose of the vaccine must be at least 6 months from the date of the initial vaccine.

Dose #1_Administration Date #1 (mm/dd/yy): _____

Dose #2_Administration Date #2 (mm/dd/yy): _____

Dose #3_Administration Date #3 (mm/dd/yy): _____

OR

The 2-dose series (Heplisav-B) of the vaccine requires a minimum of 4 weeks between doses. The administration record must clearly identify the Heplisav-B series was given.

Heplisav-B Dose #1_Administration Date #1 (mm/dd/yy): _____

Heplisav-B Dose #2_Administration Date #2 (mm/dd/yy): _____

Note: It is the student's responsibility to schedule necessary vaccination titers or the necessary boosters/challenges. Upload documentation of this additional information into your Clinical Student account.

TUBERCULOSIS (TB) TESTING: Must be completed between stated deadlines in Clinical Student.

Students may opt to either receive the TB Blood Test or the 2-Step TB Skin Test.

TB Blood Test Type (circle test): T-Spot or QuantiFERon

Date of Blood Test (mm/dd/yy):_____ Circle Results: Positive Negative

Addendum C

2022 St. David's School of Nursing – Texas State University Immunizations and Tests Form

Student Name:_____**TXST ID: A0**_____ **Date of Birth:** _____

OR

2-Step TB Skin Test:

First Skin Test administration date (mm/dd/yy): _____ Date read (mm/dd/yy): _____ Positive Negative

Second Skin Test administration date (mm/dd/yy): _____ Date read (mm/dd/yy): _____ Positive Negative

Attention healthcare provider: Students choosing the 2-Step skin test are required to receive two negative skin tests (per CDC guidelines for healthcare providers.) The second administration must be completed 7 – 21 days from the date the first TST result was read.

If a student tests positive for TB, include a synopsis of their treatment plan with this form. If appropriate, the following are minimum requirements to be included in this plan:

- Blood test (T-Spot or QuantiFERon) if prior positive blood test
- Blood test (T-Spot or QuantiFERon) if prior BCG vaccination
- Chest X-ray within the past two years
- Current completed Tuberculosis Assessment and Symptoms Checklist. Attach the completed checklist (with student's name and DOB to this form).

Treatment plan:

_____

_____

_____

This document must be signed by the healthcare provider (MD, DO, PA, or APRN).

Healthcare provider's printed name: _____

Healthcare Facility Name (address/city/state/zip):

_____

Signature of healthcare provider: _____ Date: _____

Your signature on this form indicates you have validated the evidence of the required immunizations or tests for this student. STAMPS ARE NOT ACCEPTED.

Students: After your healthcare provider completes this Immunizations and Tests Form including his/her signature, upload the completed form and your completed Health Certificate onto your Clinical Student account.

Revised 5/10/2022

Addendum D
Texas State University
College of Health Professions
Health Certificate
For Optional Use

As a participant in the CHP clinical education, you are to complete this Health Certificate and an Immunizations and Tests Form. Make an appointment with your healthcare provider to document:

- All immunizations are completed including date of booster.
  Note: See Immunizations and Tests Form - Clinical sites may require additional immunizations and/or tests.
- Verification that you are in good physical health and free from diseases listed on the Immunizations and Tests Form.

Completed Health Certificate and Immunizations and Tests Form must be received by _____.

Student: _____
Last *First* *MI*

Address: _____
Street *City* *State* *Zip*

Telephone: ( ) _____ Date of Birth: _____ / _____ / _____

Blood Pressure: _____

I have examined: _____
(Student)

and find this student to be in good physical health. I also find the above named student is free from the diseases listed on the Immunizations and Tests Form.

Restrictions or Limitations (i.e. latex allergy*) ☐ No ☐ Yes, Explain: _____

Date: _____ Telephone: ( ) _____

Healthcare Provider Signature: _____

Printed Name: _____

Healthcare Provider's Address: _____
Street *City* *State* *Zip*

Please return this completed Heath Certificate and the Immunizations and Tests Form to:

xxprogram/department/schoolxx

Completed Health Certificate and Immunizations and Tests Form must be received by the _____.