AMENDMENT OF STUDENT TRAINING AGREEMENT
(Surgical Technology and Paramedic Programs)

THIS AMENDMENT OF STUDENT TRAINING AGREEMENT (the "Amendment"), effective as of January 15, 2013 (the "Effective Date"), is executed by and between **Las Positas College** (hereinafter "College"), and **Saint Francis Memorial Hospital**, a California nonprofit public benefit corporation (hereinafter "Hospital").

RECITALS

A. Hospital and College are parties to that certain Student Training Agreement dated as of June 1, 2011, whereby Hospital provides an Internship Experience to Students from College's Surgical Technology Program (the "Agreement").

B. Hospital and College wish to provide students from College's Allied Health Paramedic Program with an Internship Experience at Hospital and to continue performance under the Agreement upon substantially similar terms, only modified as may be further stated herein.

NOW, THEREFORE, in consideration of the mutual covenants contained herein, the parties agree as follows (capitalized terms used in this Amendment and not otherwise defined have the meanings stated in the Agreement):

1. Each and every reference in the Agreement to "Catholic Healthcare West" or "CHW" is hereby replaced with "Dignity Health."

2. Each and every reference to "Student" or "Students" shall include students from College's Surgical Technology certification program and College's Allied Health Paramedic Program.

3. Section 1.3(g) under Responsibilities as Related to Students shall be deleted in its entirety and replaced by the following: Conduct a criminal background check prior to Student's participation in the Internship Experience to include (i) search of state court records to identify past criminal conduct, including misdemeanors and felony convictions, in each County where Student has resided during past seven (7) years; and (ii) a Sex Offender Search to identify registered sex offenders through a national database search; Any criminal history identified by College shall be reported to Hospital prior to Student's participation in the Internship Experience;

4. The following shall be added to Section 1.3 Responsibilities as Related to Students:

   1.3(h) Confirm Social Security Number (SSN) trace and validation, listing names and addresses associated with SSN and confirming validity of SSN for each Student;

   1.3(i) Review the General Services Administration's List of Parties Excluded from Federal Programs (available through the Internet at http://epls.arnet.gov) and the HHS/OIG List of Excluded Individuals/Entities (available through the Internet at

http://www.hhs.gov/oig), and provide documentation to Hospital that College and Students are not excluded individuals; and

1.3(j) Require that each Student assigned to Hospital who shall have access to Hospital's computer network shall comply with and sign Dignity Health's Network Usage Policy.

5. Exhibit A shall be deleted in its entirety and replaced by the revised Exhibit A attached hereto and incorporated in this Agreement.

6. Except as expressly modified herein, the terms of the Agreement are affirmed and shall remain in full force and effect throughout the Term of the Agreement

IN WITNESS WHEREOF, this Amendment of Student Training Agreement is effective as of the date first written above.

HOSPITAL: **Saint Francis Memorial Hospital**	**COLLEGE:** **Las Positas College**
By: ______________________________ Thomas Hennessy Its: President & CEO	By: ______________________________ Lorenzo Legaspi Its: Vice Chancellor of Business Services
Date: __________________	Date: _________________

[Students must present an originally signed copy of this Exhibit A to Hospital upon commencement of the Internship Experience at Hospital]

EXHIBIT A

STUDENT DECLARATION OF RESPONSIBILITIES

I, ______________________________, hereby state, represent and agree that:
(Student Name)

1. I am over eighteen (18) years old.

2. I am a student enrolled at **Las Positas Collge** ("College"), and as such I am participating in College's clinical experience program (the "Internship Experience") at **Saint Francis Memorial Hospital** ("Hospital").

3. **I agree to provide Hospital with documentation of compliance with the following health screenings and immunizations prior to beginning the Internship Experience, and understand and agree that I am responsible for any costs associated with this requirement:**

(i) Hepatitis B:
- a. Serologic testing indicating immunity (Positive Hepatitis B antibody titer or Positive Hepatitis B surface antigen results);
- b. If Negative Hepatitis B serologic testing, documented receipt of Hepatitis B vaccination series or
- c. Statement of refusal (consistent with Hospital policy).

(ii) Varicella (Chickenpox):
- a. Serologic testing indicating immunity or laboratory confirmation of disease (Positive Varicella IgG titer);
- b. If Negative Varicella serologic testing, documented receipt of Varicella vaccination; or
- c. Statement of refusal (consistent with Hospital policy).

(iii) Rubella (German Measles) and Rubeola:
- a. Serologic testing indicating immunity (Positive Rubella and Rubeola IgM antibody);
- b. If Negative Rubella and Rubeola titer, documented receipt of MMR vaccination; or
- c. Statement of refusal (consistent with Hospital policy).

(iv) Tuberculosis:
- a. Initial TB test performed within 12 months prior to Student's assignment to Hospital.
- b. Completion of two step TB test if **no documented negative PPD test result during the 24 months preceding the initial test.**
- c. Chest X-ray performed within 6 months prior to Student's assignment to Hospital if TB test positive;

(v) Tetanus , Diphtheria and Pertussis:
- a. Completion of Tetanus, Diphtheria and acellular Pertussis vaccination within 10 years prior to assignment at Hospital; or

b. Statement of refusal (consistent with Hospital policy).

(vi) Influenza Vaccination if Student is assigned to Hospital during flu season from Sept. 1- March 31;

(vii) Negative result to a minimum 10 panel drug screen performed prior to Student's assignment to Hospital, consistent with Hospital policy.

(viii) Health History and Physical Examination report or clearance letter stating that the Student is physically capable of performing the essential functions required for the Internship Experience. Physicals to be performed within 12 months prior to Student's participation in Internship Experience at Hospital.

4. I agree to conform to all applicable Hospital policies, procedures, and regulations, and such other requirements and restrictions as may be mutually specified and agreed upon by Hospital Designated Representative and College.

5. I understand and agree that I am responsible for my own support, maintenance and living quarters while participating in the Internship Experience and that I am responsible for my own transportation to and from Hospital.

6. I understand and agree that I am responsible for my own medical care needs. I understand that Hospital will provide access to emergency medical services or first aid should the need arise while I am participating in the Internship Experience. However, I understand and agree that I am fully responsible for all costs related to general medical or emergency care, and that Hospital shall assume no cost or financial liability for providing such care.

7. I understand that, as a condition for participation in the Internship Experience, I must secure and maintain professional liability insurance in amounts not less than One Million Dollars ($1,000,000) per claim and Three Million Dollars ($3,000,000) annual aggregate if College does not secure and maintain professional liability insurance on my behalf. I further understand that said insurance must be maintained in effect so long as I remain a participant in the Internship Experience and for at least three (3) years following the termination of the Internship Experience, unless said insurance provides coverage on an occurrence basis.

8. I acknowledge that I have received training to help prevent exposure to bloodborne pathogens, consistent with the guidelines published by the U.S. Centers for Disease Control and Prevention. I shall provide documentation of such training prior to beginning my Internship Experience.

9. I acknowledge that I will receive academic credit for the Internship Experience provided at Hospital and that I will not be considered an employee of Hospital or College, nor shall I receive compensation from either Hospital or College. I further acknowledge that I am neither eligible for nor entitled to workers' compensation benefits under Hospital's coverage based upon my participation in the Internship Experience. I further acknowledge that I will not be provided any benefit plans, health insurance coverage, or medical care based upon my participation in this Internship Experience.

10. I understand that Hospital may suspend my right to participate in the Internship Experience if, in its sole judgment and discretion, my conduct or attitude threatens the health, safety or welfare of any patients, invitees, or employees at Hospital or the confidentiality of any information relating to such persons, either as individuals or collectively. I further understand that this action shall be taken by Hospital only on a temporary basis until after consultation with College. The consultation shall include an attempt to resolve the suspension, but the final decision regarding my continued participation in the Internship Experience at Hospital is vested in Hospital.

11. I agree that I shall not discriminate against any person because of race, color, religion, sex, marital status, national origin, age, physical handicap, or medical condition.

12. I further understand that Hospital has the right to suspend use of its facilities in connection with this Internship Experience should Hospital's facilities be partially damaged or destroyed and such damage is sufficient to make the facilities unsafe or unusable for their purposes.

13. I recognize that medical records, patient care information, personnel information, reports to regulatory agencies, conversations between or among any healthcare professionals may be considered privileged and should be treated with utmost confidentiality. I further understand that if it is determined that a breach in confidentiality has occurred as a result of my actions, I can be held liable for damages that result from such a breach.

I have read the foregoing. I understand and agree to the terms set forth above. I recognize that as consideration for agreeing to the said terms, Hospital will permit me to participate in the Internship Experience at Hospital.

____________________________ ________________________

Student Signature *Date*

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Typed Name of Student