



## ORGANIZATION AFFILIATION AGREEMENT

This **ORGANIZATION AFFILIATION AGREEMENT** (the "Agreement") is made as of this this 16th day of May, 2023 by and between **DRISCOLL HEALTH SYSTEM ("DRISCOLL")**, whose address is 3533 South Alameda, Corpus Christi, Texas 78411 and **HIDALGO COUNTY WIC ("Organization")** whose address is **3105 W. University Drive, Edinburg, Texas 78539**.

### WITNESSETH:

WHEREAS, Organization employs Program Participants ("Program Participants") or offers to its enrolled Program Participants a degree and/or certification program in the field(s) of certain health care programs; and

WHEREAS, Driscoll operates a children's hospital, affiliated clinics, and other health care services at facilities, both on and off campus ("Facilities"); and

WHEREAS, Organization desires to provide Program Participants a clinical learning experience through the application of knowledge and skills in actual patient-centered situations; and

WHEREAS, Driscoll has agreed to make its Facilities available to Organization for such purposes.

Now, THEREFORE, in consideration of the mutual promises contained herein, the parties hereby agree as follows:

### 1. RESPONSIBILITIES OF ORGANIZATION.

(a) **Clinical Program.** Organization shall be responsible for the implementation and operation of the clinical component of its programs at Driscoll, which programs shall be approved in advance by Driscoll. This Agreement shall cover certain clinical and nonclinical programs and experiences offered at the Facilities including but not limited to: child life, dietary/nutrition, EMT fire cadet/paramedic, health information management, health sciences, information technology, laboratory & phlebotomy, medical office assisting (clerical and clinical), nursing, occupational therapy, pharmacy, physical therapy, psychology, radiology, respiratory therapy, risk management, social work, speech therapy, surgical first assist/technology, and wound care (collectively referred to as the "Program"). Such responsibilities shall include, but not be limited to, the following:

- (i) Preparation for expectations of a clinical environment including but not limited to safety and professionalism and assurance of completion of the Driscoll Children's Hospital Self-Study Orientation prior to participant's clinical assignment at Driscoll;
- (ii) Provision of theory and practical instruction to Program Participants prior to their clinical assignments at Driscoll;
- (iii) Provide adequate documentation attesting to the competency of each Program Participant prior to performing clinical rotations;

- (iv) Preparation of Program Participant/patient assignments and rotation plans for each Program Participant and coordination of same with Driscoll;
- (v) Continuing oral and written communication with Driscoll regarding Program Participant performance and evaluation, absences and assignments of Program Participants, and other pertinent information;
- (vi) Supervision of Program Participants and their performance at Driscoll;
- (vii) Participation, with the Program Participants, in Driscoll's Quality Assurance and related programs;
- (viii) Performance of such other duties as may from time to time be agreed to between Organization and Driscoll; and
- (ix) Provide adequate documentation attesting to competency of each instructor (as applicable).

All Program Participants, faculty, employees, agents and representatives of Organization participating in the Program at Driscoll (the "Program Participants") shall be accountable to Driscoll's Administrator.

(b) **Program Participant Statements.** Organization shall require each Program Participant to sign a Statement of Responsibility, attached hereto as **Exhibit A** and a Confidentiality Agreement attached hereto as **Exhibit B**. These forms will be completed by Program Participants electronically, as part of the online orientation process.

(c) **Insurance.** Organization shall maintain insurance in amount required by law for the term of this agreement and for three years thereafter. Organization does not waive, release, or relinquish any immunity or defense available to it by law. Organization shall further, at its expense, obtain and maintain workers' compensation insurance and unemployment insurance for Organization employees assigned to Driscoll. For all insurance required by this Paragraph 1(c), Organization shall require the insurance carrier notify Driscoll at least thirty (30) days in advance of any cancellation or modification of such insurance policy and shall provide to Driscoll, upon request, certificates of insurance evidencing the above coverage and renewals thereof.

(d) **Health of Program Participants.** Organization and/or the Program Participant shall be responsible for arranging for the Program Participant's medical care and/or treatment, if necessary, including transportation in case of illness or injury while participating in the Program at Driscoll. In no event shall Driscoll be financially or otherwise responsible for said medical care and treatment. At least one (1) week prior to the beginning of Program Participants' educational experience at Driscoll, Organization must complete and provide Driscoll its Attestation Form, in the form attached hereto as **Exhibit C**. Immunization records will be kept by Organization and be made available to Driscoll, upon request. For Program Participants (**excluding those with valid medical and/or religious exemptions as per Section 1(i)**), required tests/immunizations are as follows:

- (i) IGRA or Tuberculin skin test within the past 12 months or documentation as a previous positive reactor with a chest x-ray taken within the past five (5) years and an "Annual Tuberculosis Health Questionnaire" within the past 12 months.
- (ii) Proof of Mumps, Rubella and Rubeola immunity by positive antibody titers or 2 doses of MMR.
- (iii) Varicella immunity, by positive titer or proof of 2 doses Varicella immunization.
- (iv) Proof of Hepatitis B immunization, positive titer, or noted declination of vaccine, if patient contact is anticipated.
- (v) Proof of annual influenza vaccination.
- (vi) Proof of full COVID-19 vaccinations.
- (vii) Tetanus, diphtheria and Pertussis (Tdap) within the last 10 years.

(e) **Dress Code; Breaks.** Organization shall require the Program Participant to dress in accordance with dress and personal appearance standards approved by Organization. Such standards shall be in accordance with Driscoll's standards regarding same. All Program Participants shall remain on the Driscoll premises for breaks, including meals. Program Participants shall pay for their own meals at Driscoll.

(f) **Performance.** All staff provided by Organization shall be duly licensed, certified or otherwise qualified to participate in the Program at Driscoll. Organization shall have a specially designated staff for the performance of the services specified herein. Organization and all Program Participants shall perform its and their duties and services hereunder in accordance with all relevant local, state, and federal laws and shall comply with the standards and guidelines of all applicable accrediting bodies, including but not limited to Joint Commission, and the bylaws, rules and regulations of Driscoll and any rules and regulations of Organization as may be in effect from time to time. Neither Organization nor any Program Participant shall interfere with or adversely affect the operation of Driscoll or the performance of services therein.

(g) **Background Checks.** Organization shall, in a timely manner at either Organization's expense or the Program Participant's expense, conduct (or have conducted) a background check, on an annual basis, on each and every Program Participant assigned to the Program and on each and every member of the staff/faculty responsible for supervision and/or instruction on any Driscoll property. Staff/faculty responsible for virtual supervision and/or virtual instruction, intending to visit any Driscoll property, must first notify the Center for Professional Development and Practice and must provide a background check, prior to the visit, either at the instructor's or the Organization's expense. The background check shall include, at a minimum, the following:

- (i) Social Security number verification;
- (ii) 7-year Multi-County Felony and Related Misdemeanor Criminal Record search;

- (iii) Two (2) standard employment history references (if applicable);
- (iv) HHS/OIG/Texas HHS List of Excluded Individuals/Entities - GSA List of Parties Excluded from Federal Programs;
- (v) Education verification (highest degree received);
- (vi) If applicable, professional licensure verification and professional disciplinary action check  
If applicable, certification/designation checks.

Should the background check disclose adverse information as to any Program Participant and/or member of the staff/faculty, Organization shall immediately contact Driscoll's Center for Professional Development & Practice at 361-694-5420. Driscoll will look at the adverse information on a case by case basis. Organization represents and warrants that Program Participants participating hereunder: (i) are not currently excluded, debarred, or otherwise ineligible to participate in the Federal health care programs as defined in 42 U.S.C. Section 1320a-7b(f) (the "Federal health care programs"); (ii) are not convicted of a criminal offense related to the provision of health care items or services but has not yet been excluded, debarred or otherwise declared ineligible to participate in the Federal health care programs, and (iii) are not under investigation or otherwise aware of any circumstances which may result in the Organization or a Program Participant being excluded from participation in the Federal health care programs. This shall be an ongoing representation and warranty during the term of this Agreement and the Organization shall immediately notify Driscoll of any change in status of the representation and warranty set forth in this section. Any breach of this Paragraph 1(h) shall give Driscoll the right to immediately terminate this Agreement for cause.

(h) **Bloodborne Pathogens.** Organization will ensure that all Program Participants who may be at risk for occupational exposure to blood or other potentially infectious materials will be:

- (i) Trained in accordance with the Occupational Safety and Health Administration's (OSHA) Occupational Exposure to Bloodborne Pathogens (as published in Friday, December 6, 1991 Federal Register) and any amendments thereto;
- (ii) Trained in the modes of transmission, epidemiology and symptoms of Hepatitis B virus (HBV) and Human Immunodeficiency Virus (HIV) and other bloodborne pathogens;
- (iii) Trained in the methods of control that prevent or reduce exposure including universal precautions, appropriate engineering controls, work practices and personal protective equipment;
- (iv) Provided information on the Hepatitis B vaccine, its efficacy, safety, method of administration and benefits of being vaccinated; and
- (v) Provided proper follow-up evaluation following any exposure incident.
- (vi) Program Participants are not fit tested for Airborne Mask PPE by Organization and hospital and will not be permitted to participate in care of patients with known airborne precautions.

**(i) Medical and Religious Exemption from Vaccination.** In the event that Program Participant(s) request medical and/or religious exemption(s) from the required vaccinations listed under Section 1(d), and the Organization approves and can accommodate it/them, then Organization shall adhere (and require Program Participant to adhere, as applicable) to the following requirements:

- (i) Organization will review and collect the completed applicable Medical exemption form(s) (Exhibits D and E) and/or Religious Exemption form (Exhibit F). Organization-approved exemption forms will then be submitted to Driscoll along with Exhibit C, at least one week prior to Program Participant's educational experience at Driscoll.
- (ii) Organization or individual Program Participant will provide KN95 mask which will be required to be worn within 6 feet of a patient or during patient care.
- (iii) For Covid-19 exemptions only: Weekly Covid-19 test will be administered by Organization or individual Program Participant within seventy-two (72) hours of Program Participant's first scheduled visit to Driscoll. Negative Covid-19 test results will need to be attested to on Exhibit C on a weekly basis for the entire duration of the educational experience at Driscoll. Test results will be kept by Organization and be made available to Driscoll, upon request. Program Participants will not be permitted on-site at Driscoll if their Covid-19 test result is positive, or if their Covid-19 testing cannot be completed.
- (iv) Organization is responsible for approving, testing, and adhering to the above medical and/or religious exemption mandates. Driscoll will not provide Covid-19 tests or masks to Program Participants.

## **2. RESPONSIBILITIES OF DRISCOLL.**

**(a) Access for Program Participants.** Driscoll shall accept Program Participants from Organization and cooperate in the orientation of all accepted Program Participants to Driscoll. Driscoll shall provide reasonable opportunities for such Program Participants, who shall be supervised by Organization and Driscoll, to observe and assist in various aspects of the applicable program, including patient care, to the extent permitted by applicable law and without disruption of patient care or Driscoll operations. Driscoll shall coordinate Organization's rotation and assignment schedule with its own schedule and those of other educational institutions. Driscoll shall at all times retain ultimate control of the Facilities and responsibility for patient care.

**(b) Assistance with Program Evaluations.** Upon the request of Organization, Driscoll shall assist Organization in the evaluation of each Program Participant's performance in the Program. However, Organization shall at all times remain solely responsible for the evaluation and grading of Program Participants.

## **3. MUTUAL RESPONSIBILITIES.**

The parties shall cooperate to fulfill the following mutual responsibilities:

(a) **Program Participant Status.** Program Participants shall be treated as trainees who have no expectation of receiving compensation or future employment from Driscoll or the Organization.

(b) **Courtesy Appointments.** Any courtesy appointments to faculty or staff by either the Organization or Driscoll shall be without entitlement of the individual to compensation or benefits for the appointed party.

(c) **Orientation.** Orientation material will be provided to the Organization or Program Participant by Driscoll to conduct orientation for all Program Participants, and the orientation will be completed electronically. Orientation may include such topics as: privacy and security laws, Driscoll policies and procedures, patient safety, infection control, cultural diversity and sensitivity, rights of patients, ethical aspects of care, treatment and services and process used to address ethical issues, federal or state regulatory requirements or other areas as determined by Driscoll from time to time.

#### **4. WITHDRAWAL OF PROGRAM PARTICIPANTS.**

Driscoll may deny, or request Organization to withdraw or dismiss a Program Participant from the Program at Driscoll for any reason, and/or including the following reasons: (i) when his or her clinical performance is unsatisfactory to Driscoll; (ii) when his or her behavior, in Driscoll's discretion, is disruptive or detrimental to Driscoll and/or its patients; (iii) when Driscoll determines that the Program Participant has violated the rules and regulations of Driscoll; or (iv) when the Program Participant has disclosed information that is confidential by law. In such event, Program Participant's participation in the Program at Driscoll shall immediately cease.

#### **5. INDEPENDENT CONTRACTOR; NO OTHER BENEFICIARIES.**

The parties hereby acknowledge that they are independent contractors, and neither the Organization nor any of its agents, representatives, Program Participants, or employees shall be considered agents, representatives, or employees of Driscoll. In no event shall this Agreement be construed as establishing a partnership or joint venture or similar relationship between the parties hereto. Organization shall be liable for its own debts, obligations, acts and omissions, including the payment of all required withholding, social security and other taxes or benefits. No Program Participant shall look to Driscoll for any salaries, insurance or other benefits. No Program Participant or other third person is entitled to, and shall not receive any rights under this Agreement.

#### **6. NON-DISCRIMINATION.**

There shall be no discrimination on the basis of race, national origin, religion, creed, sex, age, veteran status, or handicap in either the selection of Program Participants for participation in the Program, or as to any aspect of the clinical training; provided, however, that with respect to handicap, the handicap must not be such as would, even with reasonable accommodation, in and of itself preclude the Program Participant's effective participation in the Program.

#### **7. INDEMNIFICATION.**

To the extent permitted by applicable law and without waiving any defenses, Organization shall indemnify and hold harmless Driscoll and its subsidiaries, officers, directors, medical and nursing staff, representatives, agents and employees from and against all liabilities, claims, damages and expenses, including reasonable attorneys' fees, relating to or arising out of any act or omission of the Organization or any of its staff, Program Participants, agents, representatives and employees under this Agreement, including, but not limited to, claims

for personal injury, professional liability, or with respect to the failure to make proper payment of required taxes, withholding, employee benefits or statutory or other entitlements. Driscoll shall indemnify Organization against liabilities, claims, damages and expenses, including reasonable attorneys' fees, incurred by Organization in defending or compromising actions brought against Organization arising out of or related to Driscoll's performance of duties hereunder.

## **8. CONFIDENTIALITY.**

Organization and its agents, Program Participants, staff, representatives and employees agree to keep strictly confidential and hold in trust all confidential information of Driscoll and/or its patients and not disclose or reveal any confidential information to any third party without the express prior written consent of Driscoll. Organization shall not disclose the terms of this Agreement to any person who is not a party to this Agreement, except as required by law or as authorized by Driscoll. Unauthorized disclosure of confidential information or of the terms of this Agreement shall be a material breach of this Agreement and shall provide Driscoll with the option of pursuing remedies for breach, or, notwithstanding any other provision of this Agreement, immediately terminating this Agreement upon written notice to Organization.

## **9. TERM; TERMINATION.**

(a) **Initial Term.** The initial term of this Agreement shall be three (3) year(s), commencing on **May 16, 2023** and ending on **May 15, 2026**.

(b) **Termination.** Except as otherwise provided herein, either party may terminate this Agreement at any time without cause upon at least ninety (90) days prior written notice, provided that all Program Participants, in good standing and currently enrolled in the Program at Driscoll at the time of notice of termination shall be given the opportunity to complete their clinical Program at Driscoll, such completion not to exceed six (6) months. Either party may terminate this Agreement effective immediately, upon written notice to the other party, if there has been a material breach of this Agreement and the party fails to cure the breach within 10 days after receiving written notice of the breach.

## **10. ENTIRE AGREEMENT.**

This Agreement and its accompanying Exhibits set forth the entire Agreement with respect to the subject matter hereof and supersedes all prior agreements, oral or written, and all other communications between the parties relating to such subject matter. This Agreement may not be amended or modified except by mutual written agreement. All continuing covenants, duties and obligations herein shall survive the expiration or earlier termination of this Agreement.

## **11. SEVERABILITY.**

If any provision of this Agreement is held to be invalid or unenforceable for any reason, this Agreement shall remain in full force and effect in accordance with its terms disregarding such unenforceable or invalid provision.

## **12. CAPTIONS.**

The captions contained herein are used solely for convenience and shall not be deemed to define or limit the provisions of this Agreement.

**13. NO WAIVER.**

Any failure of a party to enforce that party's right under any provision of this Agreement shall not be construed or act as a waiver of said party's subsequent right to enforce any of the provisions contained herein.

**14. GOVERNING LAW.**

This Agreement shall be governed and construed in accordance with the laws of the State of Texas. Venue for any disputes arising out of this Agreement shall be in Hidalgo County, Texas.

**15. ASSIGNMENT; BINDING EFFECT.**

Organization may not assign or transfer any of its rights, duties or obligations under this Agreement, in whole or in part, without the prior written consent of Driscoll. This Agreement shall inure to the benefit of, and be binding upon, the parties hereto and their respective successors and permitted assigns.

**16. NOTICES.**

All notices hereunder by either party to the other shall be in writing, delivered personally, by certified or registered mail, return receipt requested, or by overnight courier, and shall be deemed to have been duly given when delivered personally or when deposited in the United States mail, postage prepaid, addressed as follows:

If to Driscoll:                      Driscoll Health System  
3533 South Alameda  
Corpus Christi, TX 78411  
Attn: Director of Center for Professional Development and Practice

If to Organization:              Hidalgo County WIC Program  
3105 W. University Dr.  
Edinburg, TX 78539  
Attn: Director

or to such other persons or places as either party may from time to time designate by written notice to the other.

**17. EXECUTION OF AGREEMENT.**

This Agreement shall not become effective or in force until all of the below named parties have fully executed this Agreement.

## **18. HIPAA REQUIREMENTS.**

The parties agree to comply with the Health Insurance Portability and Accountability Act of 1996, as codified at 42 U.S.C. Section 1320d ("HIPAA ") and any current and future regulations promulgated there under, including, without limitation, the federal privacy regulations contained in 45 C.F.R. Parts 160 and 164 ("Federal Privacy Regulations"), the federal security standards contained in 45 C.F.R. Part 142 ("Federal Security Regulations"), and the federal standards for electronic transactions contained in 45 C.F.R. Parts 160 and 162, and the Health Information Technology for Economic and Clinical Health Act (HITECH), all collectively referred to herein as "HIPAA Requirements". The parties agree not to use or further disclose any Protected Health Information (as defined in 45 C.F.R. Section 164.501) or Individually Identifiable Health Information (as defined in 42 U.S.C. Section 1320d), other than as permitted by the HIPAA Requirements and the terms of this Agreement. The parties agree to make their internal practices, books and records relating to the use and disclosure of Protected Health Information available to the Secretary of Health and Human Services to the extent required for determining compliance with the Federal Privacy Regulations. In addition, the parties agree to comply with any state laws and regulations that govern or pertain to the confidentiality, privacy, security of, and electronic and transaction code sets pertaining to, information related to patients.

The Organization shall direct its Program Participants to comply with the policies and procedures of Driscoll, including those governing the use and disclosure of individually identifiable health information under federal law. Solely for the purpose of defining the Program Participants' role in relation to the use and disclosure of Driscoll's protected health information, the Program Participants are defined as members of the Driscoll's workforce, as that term is defined by 45 CFR Section 160.103, when engaged in activities pursuant to this Agreement. However, the Program Participants are not and shall not be considered to be employees of Driscoll.

## **19. NO REQUIREMENT TO REFER.**

Nothing in this Agreement requires or obligates Organization to admit or cause the admittance of a patient to Driscoll or to use Driscoll's services. None of the benefits granted pursuant to this Agreement is conditioned on any requirement or expectation that the parties make referrals to, be in a position to make or influence referrals to, or otherwise generate business for the other party. Neither party is restricted from referring any services to, or otherwise generating any business for, any other entity of their choosing.

[Signatures page follows]

IN WITNESS WHEREOF, the Parties have executed this Agreement to be effective as of the day and year first above written.

**DRISCOLL**

Driscoll Health System

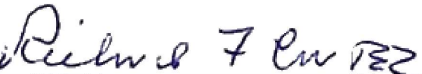
By:   
(Authorized Signature)

Name: Eric Hamon  
Title: President, CEO

Date: 5/9/2023


**ORGANIZATION**

Hidalgo County WIC Program

By:   
(Authorized Signature)

Name: Richard F. Cortez  
Title: County Judge

Date: May 17, 2023

By:   
(Authorized Signature)

Name: Arturo Guajardo, Jr.  
Title: County Clerk  
Date: May 18, 2023



**EXHIBIT A**

**STATEMENT OF RESPONSIBILITY and RELEASE OF LIABILITY  
(Please Read Carefully – This Agreement Affects Important Legal Rights)**

I UNDERSTAND THAT ACCIDENTS AND INJURIES MAY OCCUR DURING TRAVEL AND AT PARTICIPATING IN A CLINICAL LEARNING EXPERIENCE PROGRAM ("PROGRAM") AND THAT I MAY SUSTAIN SERIOUS PERSONAL INJURY. KNOWING THE RISKS, AND IN CONSIDERATION OF THE BENEFIT PROVIDED ME IN THE FORM OF A CLINICAL LEARNING EXPERIENCE AT DRISCOLL HEALTH SYSTEM, I THE UNDERSIGNED, ON MY BEHALF AND ON BEHALF OF MY HEIRS, SUCCESSORS, AND ASSIGNS AGREE TO ASSUME ALL RISKS AND BE SOLELY RESPONSIBLE FOR ANY INJURY OR LOSS SUSTAINED BY THE UNDERSIGNED WHILE PARTICIPATING IN THE PROGRAM. I AGREE TO HOLD HARMLESS AND RELEASE DRISCOLL HEALTH SYSTEM AND ITS AFFILIATES, EMPLOYEES, REPRESENTATIVES, SUCCESSORS, AGENTS AND ASSIGNS FROM ANY AND ALL LIABILITY FOR ANY AND ALL INJURY, LOSS OR DAMAGE SUSTAINED BY ME WHILE PARTICIPATING IN THE PROGRAM.

Signature of Program Participant/Staff

Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Parent/Legal Guardian if under 18

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship



### CONFIDENTIALITY AGREEMENT

**(Employees, Volunteers, Students, Contractors, Vendors, Healthcare Practitioners, Medical Students or Residents)**

Welcome to **DRISCOLL HEALTH SYSTEM (DHS)**. While at DHS or at any DHS facility, you may have access to confidential and proprietary information including information regarding patients, health plan members, associates, and the financial, administrative or health care operations of DHS (collectively "DHS Confidential Information"). DHS Confidential Information is not only a valuable and sensitive asset of DHS but is also protected by law and by DHS directives, policies, guidelines, and procedures ("policies"). DHS Confidential Information is confidential to the extent required by law and the policies of DHS, and it will only be used as necessary to care and treat the patients and health plan members of DHS or to otherwise accomplish the mission and business objectives of DHS.

DHS Confidential Information includes, but is not limited to:

- Protected Health Information (PHI) and individually identifiable health information (IIHI) as defined under the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and Modifications to the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules under the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2013.
- Sensitive Personal Information (SPI) as defined under the Texas Business and Commerce Code Chapter 521.
- Limited data sets
- All other patient/member information (records of conversation, admitting information, financial information, etc.).
- Salary, employment, personnel, health, disciplinary, educational and any other confidential or sensitive information.
- Business and financial information (financial and statistical records, strategic business plans, internal reports, memos, contracts, peer review information, communications, etc.).
- Other information relating to DHS and information proprietary to other companies or persons that DHS has and/or uses in connection with the operations of DHS (computer programs, client and vendor proprietary information, source code, or technology, etc.) in any type of relationship to DHS.
- Trade secrets and other information relating to DHS and its operations.

This agreement must be signed by any person who may have access to DHS Confidential Information, evidencing an agreement to abide by the terms set forth herein. Please read this document carefully.

By signing this Agreement, I agree to abide by all the terms and conditions stated herein.

1. Obligation to Protect. I understand that DHS Confidential Information is an important asset of DHS and that I have an obligation to protect it from misuse or unauthorized disclosure.
2. Obligation to Keep Confidential. I understand that any DHS Confidential Information to which I may have access is confidential and protected under the law and applicable regulations. I shall keep confidential all DHS Confidential Information regardless of whether it is oral, written or maintained in electronic media. I shall not discuss PHI at any DHS facility or in public areas where unauthorized individuals or those who do not have a "need to know" may overhear. I shall also keep confidential all confidential and proprietary information about DHS and its business transactions and relationships.
3. Confidentiality of Provider Information. I understand that information concerning Driscoll's contracted and credentialed providers is considered protected and confidential.
4. Disclosure to Third Parties. I understand that I am not authorized to share or disclose PHI, regardless of medium (paper, verbal, electronic, image or any other form) with or to anyone who is not part of DHS's workforce, unless otherwise permitted by this Agreement.
5. Confidentiality of Medical Records. I understand that unauthorized removal of any part of original medical records from any DHS facility is prohibited. I further understand that I may not create copies of PHI contained within medical records.

6. Compliance with Law. I shall use or disclose such DHS Confidential Information only as permitted by DHS and in compliance with all applicable federal, state, or local laws, rules, or regulations. I will not use, transfer, copy or forward any DHS Confidential Information without the express permission of DHS.
7. Use within Scope of Responsibility. I will only access DHS Confidential Information for which I have a legitimate need to know and only the minimum extent of information necessary to perform my job role at DHS. I will not in any way view, use, divulge, copy, release, sell, loan, review, alter or destroy any DHS Confidential Information except as duly authorized and within the scope of my responsibilities at DHS.
8. Appropriate Use of Confidential Information. I will not misuse or carelessly handle DHS Confidential Information. This includes information obtained through daily activities, documents, computer systems and any other information I encounter during my affiliation. I will not at any time permit any person to inappropriately access or disclose DHS Confidential Information and will use all reasonable means to prevent such disclosure or access. I understand that posting PHI or other DHS Confidential Information on social media is never permissible.
9. Ownership of Confidential Information. I understand that I have no right, title, or ownership interest in any DHS Confidential Information. DHS may at any time and for any reason revoke my access to DHS Confidential Information.
10. Obligation to Safeguard Electronic Devices. If I am provided a DHS issued electronic device (laptop, cell phone, other), I understand that I am responsible for safeguarding the device and will utilize safeguards to secure PHI.
11. Obligation to Safeguard Access. If I have access to a DHS information system, I understand that an information system may electronically assign my name to data entry sessions through my security access code, sign-on ID, or password or any other authorization I have that allows me to access and use DHS Confidential Information. I understand the importance of logging off after I have completed each data entry session. I accept responsibility for safeguarding my security or computer security access code, sign-on ID, or password and that I am directly responsible for the accuracy and completeness of data entries that are made into any computerized record. I understand that I am not authorized to share my login credentials (username and/or password) with anyone.
12. Appropriate Use of DHS Email. If I have use of DHS email, I understand that such email is the sole property of DHS and is subject to being monitored, filtered, or blocked and reviewed by DHS and I will make every possible effort to protect the privacy and confidentiality of email through appropriate safeguards and technical controls to secure transmission. I understand that there is no expectation of personal privacy in any information I send through DHS email and that my use of those systems must be limited to DHS related business in compliance with applicable policies and guidelines and in a manner consistent with the values of DHS. I also understand that email messages may be characterized as legal documents that may be used as such in legal proceedings.
13. Appropriate Use of DHS Internet. If I intend to use DHS Internet, I understand that I must make every effort to protect the privacy and confidentiality of any information through appropriate safeguards and technical controls to secure transmission. I understand the failure of DHS to prevent unauthorized use of the Internet does not relieve an individual of the responsibility for obtaining authorization prior to his or her use of the Internet and that posting PHI or other DHS Confidential Information on social media is never permissible. I understand that there is no expectation of personal privacy in any information accessed through use of DHS Internet and that DHS may monitor, filter or block Internet activity occurring on DHS equipment or information systems to ensure compliance with applicable laws, management directives, or guidelines. I also understand that if DHS discovers or suspects activities that are not in compliance, records may be retrieved and used to document wrongful use and that violations may result in a revocation of Internet access privileges and/or legal action.
14. Prohibited Use of DHS Email and Internet Access. I understand that users are solely responsible for any material they access or disseminate through DHS email and Internet and that accessing and distribution of pornography, violence, racial or gender slurs, or other inappropriate information, allowing unauthorized access by non-associates to DHS, intentionally sending or downloading viruses, creating modifying executing, copying or retransmitting computer programs, and any communication which violates applicable state and/or federal laws and regulations is prohibited. I understand that DHS assumes no liability for any direct or indirect damages arising from the user's connection to or use of the Internet or for copyright infringement resulting from the user's receipt or dissemination of works. I also understand that DHS is not responsible for the accuracy of information found on the Internet and only facilitates the access and dissemination of information through its systems.

15. Limitations on Storage. I understand that I will not copy or store DHS Confidential Information on mobile or portable devices or removable media such as personal laptops, cell phones, CDs, or removable external storage unless specifically required to do so by my job assignment and with the consent and knowledge of DHS. I will ensure that PHI stored on portable devices and media is encrypted and maintained in accordance with DHS policy and will implement appropriate administrative, physical, technical controls reasonably necessary to prevent unauthorized access, use, or disclosure of DHS Confidential Information.
16. Revocation of Access. I understand that I have no right, title, or ownership interest in any DHS Confidential Information. I understand that DHS may at any time and for any reason revoke my access to DHS Confidential Information.
17. Breach Notification. Should DHS Confidential Information be accidentally revealed because of my action or inaction, or if I learn of a potential breach of DHS Confidential Information from other sources, I will immediately report the breach to my supervisor at DHS and the DHS Chief Privacy Officer at (361) 694-4808 and take immediate action to mitigate the breach. If I become aware of a legal proceeding, subpoena, or governmental request, to disclose DHS Confidential Information, I shall promptly notify DHS of any such request so that the DHS may seek a protective order or other appropriate remedy prior to the disclosure of Confidential Information.
18. Familiarity with Regulations and DHS Policy. It is my responsibility to be familiar with the HIPAA, HITECH (Health Information Technology for Economic and Clinical Health Act) and state regulations related to privacy and security as well as DHS HIPAA policies.
19. Return or Destruction of Health Information. If, as part of my job responsibilities, I must take PHI off the premises of any DHS facility, I shall have DHS's permission to do so, I shall protect all PHI from disclosure to others, and I shall ensure that all PHI removed from DHS facilities is returned in its original form to DHS.
20. Sanctions. I understand that unauthorized access or disclosure of PHI may violate state or federal law, cause irreparable injury and/or harm to the affected individual(s) and may result in disciplinary action, including termination of my employment.

I understand that my obligations under this Agreement will continue after termination of my relationship with DHS. Upon termination I will immediately return any document or media containing DHS Health Information to DHS or destroy it in accordance with NIST Guidelines for media sanitization <https://csrc.nist.gov/>.

I have read and understand this Confidentiality Agreement and agree to abide by the terms hereof. Any failure on my part to abide by this Agreement or DHS policies may result in the immediate termination of my authorization, access to and/or use of DHS Confidential Information and/or appropriate legal action.

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Company/Group Name (if applicable)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Address

\_\_\_\_\_  
Date



Exhibit D



REQUEST FOR MEDICAL EXEMPTION FORM

Please print the following information:

Name: \_\_\_\_\_
Email: \_\_\_\_\_
Department: \_\_\_\_\_
Provider name: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_
Phone: \_\_\_\_\_
Supervisor: \_\_\_\_\_
Provider phone: \_\_\_\_\_

As a patient safety and health care personnel safety initiative, Driscoll Health System is requiring vaccinations against diseases listed below for Persons Affected.

Medical exemption from vaccinations may be allowed for contraindications or precautions identified by the Centers for Disease Control and Prevention. Please complete the form below to request medical exemption for your patient. If you have any questions, please contact Driscoll Children's Hospital Occupational Health Department at 361-694-6718.

My patient should not be vaccinated against: [ ]Tdap [ ]Influenza [ ]MMR [ ]Varicella [ ]HepB

for the following CONTRAINDICATION REASONS LISTED BY CDC: (Please list the recognized contraindications per CDC guidelines):

Four horizontal lines for listing contraindications.

This is a: Temporary Medical Condition Permanent Medical Condition

- I have reviewed the CDC contraindications and precautions for checked immunization
I am attaching supporting DOCUMENTATION or MEDICAL RECORDS
I certify that my patient has the above contraindications and request medical exemption from DHS's vaccination policy
I understand that I could be contacted for additional clarification

I certify that my patient has the above contraindications and request medical exemption from DHS's vaccination policy. I understand that I could be contacted for additional clarification.

Name of Medical Practitioner (MD, DO, APRN, PA): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_
Signature stamps are not acceptable

PLEASE INCLUDE EXEMPTION FORM WITH EXHIBIT C AND SUBMIT TO DCHSTUDENTSCHEDULING@DCHSTX.ORG

Designated Office Use Only:

Medical Exemption Approved on: \_\_\_\_/\_\_\_\_/\_\_\_\_
Approving Staff Signature: \_\_\_\_\_

Exhibit E



REQUEST FOR MEDICAL EXEMPTION FORM – COVID-19

Please print the following information:

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_
Email: \_\_\_\_\_ Phone: \_\_\_\_\_
Department: \_\_\_\_\_ Supervisor: \_\_\_\_\_
Provider name: \_\_\_\_\_ Provider phone: \_\_\_\_\_

As a patient safety and health care personnel safety initiative, Driscoll Health System is requiring full Covid vaccination status. Medical exemption from the Covid-19 vaccination may be allowed for contraindications or precautions identified by the Centers for Disease Control and Prevention (CDC). Please complete the form below to request medical exemption for your patient based on CDC Contraindications and Precautions to Covid-19 Vaccination guidelines. If you have any questions, please contact Driscoll Children's Hospital Occupational Health Department at 361-694-6718.

My patient should not be vaccinated against the following Covid-19 vaccination:

- ☐ Pfizer ☐ Moderna ☐ Janssen ☐ Other: \_\_\_\_\_ Covid-19 immunization

for the following CONTRAINDICATION REASONS LISTED BY CDC: (Please list the recognized contraindications per CDC guidelines):

\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_

- ☐ I have reviewed the CDC contraindications and precautions to Covid-19 Vaccination
☐ I am attaching supporting DOCUMENTATION or MEDICAL RECORDS
☐ I certify that my patient has the above contraindications and request medical exemption from DHS's vaccination policy
☐ I understand that I could be contacted for additional clarification

Name of Medical Practitioner (MD, DO, APRN, PA): \_\_\_\_\_ Ph#: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature stamps are not acceptable

PLEASE INCLUDE EXEMPTION FORM WITH EXHIBIT C AND SUBMIT TO DCHSTUDENTSCHEDULING@DCHSTX.ORG

Designated Office Use Only:

Medical Exemption Approved on: \_\_\_\_/\_\_\_\_/\_\_\_\_
Approving Staff Signature: \_\_\_\_\_

Exhibit F



**Driscoll**  
Health System

**REQUEST FOR RELIGIOUS EXEMPTION FORM**

Please print the following information:

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Email: \_\_\_\_\_ Phone: \_\_\_\_\_  
School/Organization: \_\_\_\_\_ Supervisor: \_\_\_\_\_  
Date of Request Submission: \_\_\_\_\_

Immunization exemption is requested for:  Covid-19  Tdap  Influenza  MMR  Varicella  HepB

As a patient safety and health care personnel safety initiative, Driscoll Health System (DHS) is requiring vaccinations against diseases listed below for health care personnel. Vaccinations against the diseases listed have been recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control for health care personnel and have been shown to be effective in protecting patients from these diseases and complications related to them. Increasingly, national professional, health care, and infection prevention organizations are recommending that health care organizations require certain vaccinations to protect the health and safety of patients, employees, patient and employee family members, and the community as a whole from these diseases.

DHS will recognize exemptions to the vaccination policy for religious reasons. The individual identified above is requesting to be exempt from vaccinations for religious reasons. Please confirm that the individual follows religious beliefs that would qualify for an exemption by completing the information below. If you have questions, please contact

NAME OF RELIGION: \_\_\_\_\_

NAME AND ADDRESS OF RELIGIOUS ORGANIZATION: \_\_\_\_\_

DESCRIPTION OF RELIGIOUS DOCTRINE OR PRACTICE THAT IS CONTRARY TO VACCINATIONS (can attach document if needed):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I certify that the above individual practices a religion where vaccinations are contraindicated according to doctrine or accepted religious practices. I understand that I could be contacted for additional clarification.

SIGNATURE OF PERSON REQUESTING EXEMPTION AND LAST 4 OF

SS#: \_\_\_\_\_ / \_\_\_\_\_

**PLEASE INCLUDE EXEMPTION FORM WITH EXHIBIT C AND SUBMIT TO DCHSTUDENTSCHEDULING@DCHSTX.ORG**

**Designated Office Use Only:**

Religious Exemption Approved on: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Approving Staff Signature: \_\_\_\_\_

**APPROVED**

**I. WIC**

P 4/1 ✓  
1. AI-90745 Requesting approval to enter into an Organizational Affiliations Agreement with Driscoll Health System to provide a clinical learning experience for HC WIC Program participants at no cost to the County, with authority for the County Judge and WIC Director, to sign all required documents.

**J. Elections Department**

OK ✓  
1. AI-90740 Requesting authorization to continue "Sole Source Declaration" for Software as a Service Agreement for Online Poll-Worker Training with SOE Software dba/SCYTL with authority to purchase and continue with the amended agreement for the following years of service:

P 1/2 ↓

SERVICE	FEE	Invoice Date
SCYTL Online Poll-worker Training September 01, 2023 - September 01, 2024	\$14,000	09/01/2023
SCYTL Online Poll-worker Training September 01, 2024 - September 01, 2025	\$14,000	09/01/2024
SCYTL Online Poll-worker Training September 01, 2025 - September 01, 2026	\$14,000	09/01/2025

**K. Sheriff's Office**

OK ✓  
P 1/2  
1. AI-90698 Requesting approval of the Certificate of Substantial Completion for the Hidalgo County Sheriff's Office Shooting Range Improvements project, as submitted by contractor, Noble Texas Builders, with authority for the Sheriff or the County Judge to sign all required documents.

**L. Juvenile Probation**

OK ✓  
P 1/2  
1. AI-90826 A. Presentation of scoring grid for the purpose of ranking by HCCC of graded vendors submissions with the recommendation by the Evaluation Committee Members for "Juvenile Drug Court Program" (RFP 23-0097-05-03-ABV):

Evaluators	Wellness Center	Reset Counseling Center
Evaluator 1	20	18
Evaluator 2	22	19
Evaluator 3	20	18
Total Score	62	55

P 4/2 ✓  
B. Authority for the Purchasing Department to negotiate an agreement with the No. 1 highest ranked participating vendor Wellness Center, for the Juvenile Drug Court Program.










# C-23-0158-05-16 OAA between HC WIC and Driscoll Health System

Final Audit Report

2023-05-18

Created:	2023-05-18
By:	Ived Sepulveda (ived.sepulveda@co.hidalgo.tx.us)
Status:	Signed
Transaction ID:	CBJCHBCAABAA3nm6z4jOeC6UHyJKV_QnHXUcSr5QL1uZ

## "C-23-0158-05-16 OAA between HC WIC and Driscoll Health System" History

-  Document created by Ived Sepulveda (ived.sepulveda@co.hidalgo.tx.us)  
2023-05-18 - 6:39:34 PM GMT
-  Document emailed to arturo.guajardo@co.hidalgo.tx.us for signature  
2023-05-18 - 6:40:35 PM GMT
-  Email viewed by arturo.guajardo@co.hidalgo.tx.us  
2023-05-18 - 7:45:36 PM GMT
-  Signer arturo.guajardo@co.hidalgo.tx.us entered name at signing as Arturo Guajardo Jr  
2023-05-18 - 7:46:21 PM GMT
-  Document e-signed by Arturo Guajardo Jr (arturo.guajardo@co.hidalgo.tx.us)  
Signature Date: 2023-05-18 - 7:46:23 PM GMT - Time Source: server
-  Document emailed to Carolyn Thornton (carolyn.thornton@co.hidalgo.tx.us) for approval  
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-  Email viewed by Carolyn Thornton (carolyn.thornton@co.hidalgo.tx.us)  
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-  Document approved by Carolyn Thornton (carolyn.thornton@co.hidalgo.tx.us)  
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