Certified Athletic Trainer Agreement for Services 2018 – 2021

This Agreement for Services ("**Agreement**") is entered into by and between Marin General Hospital, a California nonprofit public benefit corporation ("**Hospital**"), and San Rafael High School District ("**SRHSD**"). In consideration of the mutual promises made in this Agreement, the parties agree as follows.

SERVICES

1. A BOC Certified Athletic Trainer employed by the Hospital will be available to provide training services to the Schools on a regularly scheduled basis.
2. The agreed-upon services will include evaluation and treatment of injuries sustained by SRHSD's students during school athletic events, application of first aid and recommendation for exercise or physical measures for minor injuries under the direction, supervision, and review of Orthopedic/ Sports Medicine Medical Directors.
3. The Athletic Trainer will be responsible for the athletic training facility while there, including opening and closing. The Athletic Trainer will also advise the school on inventory status, requisitioning of supplies (i.e., tape, pre-wrap, etc.), and or facility management.
4. The Athletic Trainer will keep accurate records on EMR of all athletic injuries reported by school students as occurring during school athletic events and all rehabilitation procedures administered by Athletic Trainer. The Athletic Trainer will also prepare reports on all athletic injuries sustained by school students during school events for the nursing and athletic offices as may be requested. The Certified Athletic Trainer shall comply with all school policies regarding confidentiality of information and records.
5. In cooperation with the Athletic Director and staff, the Athletic Trainer will develop and distribute to Athletic Director, Nurse, Coaches, and Sports Medicine Medical Director, the following information: location of the emergency phone and phone numbers.
6. Inspect and take inventory of all team medical kits prior to the beginning of each season.
7. Provide coordination between injured athletes, coaching staff, and team or family physician.
8. The Athletic Trainer shall report directly to the Hospital's Wellness Programs Management and Orthopedic Sports Medicine Medical Directors and shall work with Athletic Director or his/her designee in terms of administering services to student-athletes.
9. The Athletic Trainer will develop and distribute emergency procedures and emergency phone numbers.

San Rafael High School District

1. Hospital will provide on-site athletic trainer services to San Rafael High School and Terra Linda High School.
2. Services to begin on July 23, 2018, and concluding no later than Saturday, June 15, 2021, or when the last School's athletic competition occurs.
3. The Athletic Trainer will attend all away Football games.
4. Basic days of service to be Monday through Friday.
5. Basic service week to be a minimum of five hours per day and thirty hours per week.
6. Basic hours of service, when school is in session, shall be from 2:30 PM until 7:30 PM.
7. SRHSD reserves the right to adjust the basic hours of service if notice is given, in writing, no less than three (3) days prior to the practice or event which requires service.
8. Basic hours of services will be adjusted during breaks or calendared holidays when SRHSD athletes are practicing or competing with a minimum notice of seven (7) working days prior to the start date of the holiday.
9. Attend all designated Saturday events; approximately twenty (20) days.
10. The Athletic Trainer will travel and provide services to any SRHSD Athletic Team engaged in Marin County Athletic League, North Coast Section or California Interscholastic playoff events as requested by SRHSD.
11. The Provider shall monitor, maintain and re-purpose an impact alert system assigned to SRHSD athletes per the agreement reached with the supplier of the impact monitoring devices.

DUTIES AND RESPONSIBILITIES OF SRHSD

1. Athletic training and first aid supplies
2. Facilities to house the Athletic Trainer.
3. Basic athletic training equipment.
4. Providing internet and email access for the Athletic Trainer.
5. Supplying the Athletic Trainer with reasonable protection from harsh weather conditions
6. Providing a safe work environment for the Athletic Trainer.
7. SRHSD does **not** assume the responsibility for transporting the Athletic Trainer to events **unless** transportation is provided for the competing team.
8. SRHSD will make all of the payments and will process payment at the end of the month.
9. Parents of all minor athletes must complete the Authorization for Certified Athletic Trainer Services and Consent to Treatment attached hereto as **Exhibit A**, and return same to Hospital prior to the start of Services.

PAYMENT

1. **Payment**. For all Services rendered by Hospital pursuant to this Agreement, SRHSD shall pay to Hospital compensation in the amounts set forth on **Exhibit B**. Payment terms are net 30 days from date of Marin General Hospital receipt of invoice.

TERM AND INDEMNITY

1. **Term of Agreement.** This Agreement shall commence as of the effective date of July 23, 2018, and shall term on June 15, 2021, unless sooner terminated as follows:
2. **Termination Without Cause**. Either party, at any time during the term of this Agreement and for any reason, may terminate this Agreement or any purchase order upon giving the other party thirty (30) days prior written notice. Termination of this Agreement shall not act as a waiver of, or as a release from liability for, any breach of this Agreement. Termination or expiration of this Agreement shall not affect or negate any obligation of either party to the other arising prior to the date of such termination or expiration.
3. **Termination for Cause.** Either party may terminate this Agreement upon written notice to the other party (the Breaching Party) if the Breaching Party (a) is in material breach of any provision of this Agreement and such breach adversely impacts the rights and benefits of the non-breaching party under this Agreement and (b) the Breaching Party has failed to cure such breach within thirty (30) calendar days after receiving written notice from the non-Breaching Party reasonably describing the breach.
4. **Indemnification**. Each party (the "Indemnifying Party") shall indemnify, defend and hold harmless the other party and its officers, directors, trustees, and employees from and against any claim, demand, liability, loss, judgment, settlement, suit, action, cost or expense, including reasonable attorneys' fees, arising out of or incident to: (i) the negligent or intentional acts or omissions of the Indemnifying Party, its officers, directors or employees in connection with this Agreement; and (ii) the use or provision of Products that involves any acts or omissions of the Provider for which strict or products liability may be alleged.
5. **Medicare/Medicaid**. Each party represents that to its knowledge it and its employees and agents are not currently, nor have they ever been, under investigation by any governmental authority with respect to any matter that could give rise to suspension or debarment under any federal or state health care program or to criminal liability and has no reason to believe that there are any bases for such investigations. Each Party shall immediately notify the other party if it believes that it or any of its employees or agents is subject to government investigation. In addition, each party represents that it and its employees and agents have no prior convictions for a health care related offense and are not currently suspended or debarred from participating in any federal or state health care program.
6. **Insurance.** Each party agrees to maintain a policy of comprehensive commercial general liability insurance with coverage of at least one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) in the annual aggregate; (b) workers'

compensation insurance as required by applicable state law and employers' liability insurance; (c) professional liability insurance with coverage of at least one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) in the annual aggregate. Notwithstanding subsection (b) above, because workers' compensation coverage does not extend to owners of companies, including sole proprietors, Each party retains responsibility for any work-related/on-the-job injuries.

7. **Dispute Resolution**. If the parties cannot resolve a dispute between them relating to this Agreement after using good faith efforts to resolve the dispute informally, the parties shall submit the dispute to binding arbitration in accordance with the then prevailing Commercial Arbitration Rules of JAMS/Endispute. The parties shall bear the arbitrator's fees and expenses equally. The place of arbitration shall be the County of Marin, California. Judgment upon the award may be entered and enforced in the appropriate state or federal court sitting in the county where arbitration is located.

8. **Amendments**. This Agreement may be amended only by a writing signed by both parties.

9. **Independent Contractor**. Hospital, in the performance of this Agreement, shall be and act as an independent contractor. Hospital understands and agrees that they and all of their employees shall not be considered officers, employees, agents, partner, or joint venture of the District, and are not entitled to benefits of any kind or nature normally provided employees of the District and/or to which District's employees are normally entitled, including, but not limited to, State Unemployment Compensation or Worker's Compensation, property & liability, and sexual harassment insurance. Hospital shall assume full responsibility for payment of all federal, state and local taxes or contributions, including unemployment insurance, social security and income taxes with respect to Hospital employees.

10. **Submittal of Documents**. The Hospital shall not commence the Work under this Contract until the Hospital has submitted and the District has approved the certificate(s) and affidavit(s), and the endorsement(s) of insurance required as indicated below:

    X Signed Agreement
    X Workers' Compensation Certificate
    X Criminal Background Investigation Certification
    X Insurance Certificates and Endorsements
    X W-9 Form

IN WITNESS WHEREOF, the parties hereto have duly executed this Agreement on the date below to be effective as of the Effective Date.

_____	_____
San Rafael City Schools, Douglas Marquand, Assistant Superintendent of Business Services	Date
_____	_____
Marin General Hospital, James P. McManus, CFO	Date

EXHIBIT A

AUTHORIZATION FOR CERTIFIED ATHLETIC TRAINER SERVICES AND CONSENT TO TREATMENT

I, the undersigned, am the parent/legal guardian of,_____, a minor and athlete at
(Athlete name - please print)
_____who plans on participating in_____.
(Name of School) *(Sport)*

I understand that Marin General Hospital ("MGH") is contracted by the school to provide sports medicine services for the school's athletes. I hereby give consent for a Certified Athletic Trainer and/or other MGH sports medicine clinical staff to provide sports medicine services for the above minor. Sports medicine services include, but are not limited to: administrating first aid for athletic injuries, providing initial treatment and management of acute injuries, and assessing athletic injuries at the request of the athlete, the athlete's coach, or the athlete's parent/guardian. The Athletic Trainer and/or sports medicine clinical staff will perform only those procedures that are within their training, credential limitations and scope of professional practice to prevent, care for and rehabilitate athletic injuries. I understand that a written report of any athletic injury assessment for the athlete will be confidentially maintained in the files of the training room or school's office.

I, hereby authorize the Athletic Trainer and/or other MGH clinical staff who provide services to the above-named athlete to disclose information about the athlete's injury assessments and post-injury status. I understand such disclosures will be done, as needed, with the involved coaching staff, any treating healthcare provider and/or consulting concussion management specialist.

I understand that there is no charge to me for the above listed athletic training services. If the athlete is in need of further treatment by a physician, or of rehabilitation services for the injury, he or she may see the physician or provider of his/her choice.

Injured athletes that have been evaluated and/or treated by a physician must submit written clearance from that physician to the Athletic Trainer prior to the athlete being permitted to resume activity. In circumstances where an athlete has been removed from play because of a suspected head injury or concussion, the athlete will not be permitted to return to play until the athlete is evaluated by a healthcare provider, receives medical clearance and written authorization from that provider. This Authorization shall remain in effect for one sports season beginning with the date set forth below.

Parent/Guardian Name(print)_____Signature_____Date_____
Relationship to athlete_____Cell/Work phone_____
Home Address_____Home phone_____

Athlete Name_____Sex Grade Date of Birth_____
Allergies_____
Current Medications (ie asthma inhalers, epi-pen, etc) _____
Physical impairments_____
Other pertinent medical history (surgeries, diabetes, seizures, heart condition, etc) _____

_____

_____

Physician Name_____Physician Phone_____

Pre-Participation Head Injury/Concussion Reporting:
Has athlete ever experienced a traumatic head injury (a blow to the head)? Yes No If yes, when? Dates (month/year)_____
Has athlete ever received medical attention for a head injury? Yes No If yes, when? Dates (month/year)_____
If yes, please describe the circumstances:_____
Was athlete diagnosed with a concussion? Yes No If yes, when? Dates (month/year)_____
Duration of symptoms (such as headache, difficulty concentrating, fatigue) for most recent concussion:_____

_____ _____
Athlete Signature *Parent/Guardian Signature*

Statement Acknowledging Receipt of Education and Responsibility to Report Signs/Symptoms of Concussion:

I,_____of_____School hereby acknowledge having received education about the signs, symptoms and risk of sports related concussion. I also acknowledge my responsibility to report to the coaches and my parent(s)/guardian(s) any signs/symptoms of a concussion.

_____ _____
Signature and Printed Name of athlete *Date*

I, the parent/guardian of the athlete named above, hereby acknowledge having received education about the signs/symptoms and risks of sport related concussion and acknowledge my responsibility to report to the coaches, any signs/symptoms of a concussion in the above minor.

_____ _____
Signature and Printed Name of parent/guardian *Date*

EXHIBIT B

RATE SCHEDULE

1. Athletic Training program rate per school:

   Year 1 $53,000
   Year 2 $55,000
   Year 3 $57,000

2. Hospital will issue 11 monthly invoices (August-June) per year to SRHSD.