APPENDIX B
External Healthcare Provider
Memorandum of Understanding

Patient Label

I acknowledge that I fully understand and agree to abide by the following terms and conditions with respect to my care of patient, _____ at Quinte Health Care (QHC).

Terms and Conditions:

- ☐ I have reviewed and will comply with QHC External Healthcare Providers Policy #3.11.11 and Confidentiality Policy # 4.2.

- ☐ I represent and warrant, and it is a condition of this Agreement, that I have obtained the express informed written consent from the patient/substitute decision maker.

- ☐ I represent and warrant, and it is a condition of this Agreement, that I am certified and/or registered by the appropriate governing body to carry out the contemplated care with respect to the patient and that I shall deliver care in a professional and timely manner in accordance with any and all legislation, regulations and professional standards.

- ☐ In accordance with the above named policy, I hereby agree to provide the patient's healthcare team with any and all, written or verbal, updates with respect to my care of the patient on an ongoing basis.

- ☐ I agree to defend, indemnify and save Quinte Health Care Corporation harmless from all loss, cost, expense, judgment or damage on account of injury to persons including death or damage to property, in any way caused by the negligence of the External Healthcare Provider, its servants, agents, or employees related to or arising out of programs or other matters to which this agreement pertains, together with all legal expenses and costs incurred by Quinte Health Care Corporation in defending any legal action pertaining to the above.

- ☐ During the term of this agreement I shall maintain in full force and effect general liability insurance and professional liability insurance each for a minimum of $5,000,000 any one occurrence. Such insurance shall name Quinte Health Care Corporation as additional insured but only with respect to this agreement. I will provide Quinte Health Care Corporation with evidence of insurance upon request.

- ☐ I will provide Quinte Health Care written notice of material change to, cancellation or non-renewal of this policy.

☐ The general liability insurance shall include, at minimum, the following:
- Products and completed operations;
- Personal injury;
- Cross liability;
- Contractual liability

☐ I agree to strictly guard and maintain the confidentiality of any personal health information, or any hospital administrative information, to which I gain access during this experience. I agree to adhere to QHC Confidentiality Policy #4.2 and have signed a QHC confidentiality agreement.

☐ I acknowledge that any violation on my part of the terms and conditions shall result in the immediate denial of access to the patients at Quinte Health Care.

☐ I acknowledge that I am not a member of the staff, or an employee, nor am I an independent contractor nor otherwise engaged by Quinte Health Care (QHC). I acknowledge that I am to receive no remuneration from QHC and I am not entitled to any benefits in accordance with the *Workplace Safety Insurance Act*.

External Healthcare Provider Name (print) **Signature**

Date (DD/MM/YYYY)

STAFF INSTRUCTIONS
Please place the original copy of this form on the patient's chart and provide the patient/SDM with a photocopy