



Clinical Affiliation Candidate Form

Please complete this form and email to:

- **CPT Danville:** danielle.peppler@centerforpediatrictherapies.com (OT/PT),
tia.crumpton@centerforpediatrictherapies.com (SLP)
- **CPT Lynchburg:** chrissy.putney@centerforpediatrictherapies.com (OT/PT),
meagan.stanger@centerforpediatrictherapies.com (SLP)
- **CPT Martinsville:** danielle.peppler@centerforpediatrictherapies.com
- **CPT South Boston:** morgan.trent@centerforpediatrictherapies.com
- **CPC:** christina.horton@centerforpediatrictherapies.com
- **BBCVA:** malorie.kidd@centerforpediatrictherapies.com
- **BBSVA:** hunter.willard@centerforpediatrictherapies.com

Name	
Email	
Phone Number	
Date of Birth	
School Information	<input type="checkbox"/> Undergraduate <input type="checkbox"/> Graduate List major: _____
Discipline (check all that apply)	<input type="checkbox"/> OT <input type="checkbox"/> SLP <input type="checkbox"/> School/Teacher <input type="checkbox"/> PT <input type="checkbox"/> Autism/Behavior
Location	<input type="checkbox"/> Danville <input type="checkbox"/> Martinsville <input type="checkbox"/> Lynchburg & Roanoke <input type="checkbox"/> South Boston
Hours	Number of Hours Required for Internship: Direct: Total:
Scheduling	I am available: <input type="checkbox"/> Monday (Hours: _____) Semester Begins: _____ <input type="checkbox"/> Tuesday (Hours: _____) Semester Ends: _____ <input type="checkbox"/> Wednesday (Hours: _____) <input type="checkbox"/> Thursday (Hours: _____) Date Range Available: <input type="checkbox"/> Friday (Hours: _____) _____
Additional Information	Are you unavailable any dates within your time frame (vacation, etc.)? List dates: _____



EXHIBIT A

RESPONSIBILITY AND CONFIDENTIALITY STATEMENT

For and in consideration of the benefit provided the undersigned in the form of experience in evaluation and treatment of patients of _____ (“Facility”), the undersigned and his/her heirs, successors and/or assigns do hereby covenant and agree to assume all risks of, and be solely responsible for, any injury or loss sustained by the undersigned while participating in the observation at Facility unless such injury or loss arises solely out of Facility’s gross negligence or willful misconduct.

My sponsoring facility, academic facility, employer or I have personally provided evidence of my professional and/or general liability insurance to the Facility department authorizing my observation activity. If I do not provide evidence of insurance, I am personally liable for all injury, illnesses, or damages to myself or others related to my participation in this event. I hereby release, hold harmless, acquit, and forever discharge the Facility, Center for Pediatric Therapies, Inc., All Care Home Health, Inc., Accelerated Care, Inc., Martinsville Physical Therapy & Industrial Rehabilitation, Inc., Danville Orthopedic & Athletic Rehabilitation, Inc., and each of these entities, their agents, servants, successors or assigns, for any and all actions, causes of action, claims, demands, damages, costs, expenses, any present or future healthcare charges related or unrelated to medical treatment and compensation, arising out of, or related in any way to my observation in patient care areas in this Facility or its associated entities.

In addition, the undersigned agrees to:

1. Abide by the Policies and Procedures of the Facility;
2. Comply with all applicable federal, state and local statutes and regulations in connection with the observation;
3. Obtain prior written approval from the Facility before publishing any materials relating to the observation.

The undersigned hereby acknowledges his/her responsibility under applicable Federal law to keep confidential any information regarding Facility patients, as well as all confidential information of Facility. The undersigned agrees, under the penalty of law, not to reveal to any person or persons except authorized clinical staff and associated personnel any specific information regarding any patient and further agrees not to reveal to any third party any confidential information of Facility, except as required by law or as authorized by Facility.

Participant Name Date

Participant Signature Date

Parent or Guardian Name if Participant is a Minor Date

Parent or Guardian Signature if Participant is a Minor Date

Witness Name Date

Witness Signature Date

Location Manager Signature Date



EXHIBIT B

CONFIDENTIALITY STATEMENT

The Health Insurance Portability and Accountability Act Privacy Regulations

As of April 14, 2003, the federal Health Insurance Portability and Accountability Act (HIPAA) provides patient protections in connection with the use and disclosure of their health information, in addition to those protections that already exist under state law.

_____ (“Facility”),
are committed to protecting the privacy and security of our patients’ health information.

By signing this statement, I acknowledge my responsibility under state and federal law and agree not to disclose or share with others, and keep confidential, any information regarding Facility parents and proprietary information of Facility. I agree that if I have access to patient information, not to reveal to any patient specific information, including that this person is a patient at the Facility and any information I may learn about the circumstances of the patient’s care, and further agree not to reveal to anyone else any confidential information of this Facility. I agree to comply with any patient information privacy and security policies and procedures of the Facility. I further acknowledge that the importance of patient privacy, security and confidentiality has also been verbally discussed with me, and that I had an opportunity to ask questions regarding the Facility’s privacy and security policies, procedures and practices.

I have read and understand the terms of this statement and agree to abide by these terms. Should I choose to reveal confidential patient information to anyone. I acknowledge that the Facility provided me with the applicable information and training in order to prevent any and all violations of the laws regarding patient privacy, security and confidentiality.

Participant Name Date

Participant Signature Date

Parent or Guardian Name if Participant is a Minor Date

Parent or Guardian Signature if Participant is a Minor Date

Witness Name Date

Witness Signature Date

Location Manager Signature Date