Intermountain Health

November 2, 2023

Warranty and Attestation

for Non-Intermountain Clinical and Non-Clinical Worker

Employer / Worker Information

Please PRINT

- Worker's Full Name _____
- Job Function / Role _____
- Employer _____
- Affiliated physician/dentist if different from Employer _____
- Employer Phone _____
- Assigned Intermountain Manager if known _____

Warranty

Employer warrants that its Worker: (a) complies with all applicable state or federal licensing, accreditation, certification, and/or professional registration requirements; (b) has not made and will not make any representation, warranty, guarantee, or statement that contains an untrue statement or omits a material fact; (c) has the experience and skill to perform the services required; and (d) has never been the subject of a substantiated complaint, grievance or disciplinary proceeding of any kind.

Employer further warrants that the services rendered comply with all applicable state or federal laws and do not infringe on or violate the intellectual property rights of any third party. Employer must provide Intermountain with immediate notification of changes in Worker's employment status, ability to perform services, or any items noted on this form. Intermountain maintains the right to terminate Worker's work assignment and may consider its other legal options if Employer fails to meet these obligations.

Insurance and Liability Obligations

Employer will secure and maintain insurance for its Worker as follows:

(a) General and Professional Liability Insurance with limits of at least $1,000,000 per claim with a $3,000,000 annual aggregate;

(b) Workers' Compensation Insurance meeting the minimum amounts of coverage required by the state where the worker is providing services.

Upon request of Intermountain, Employer shall provide proof of the insurance coverage required herein.

Intermountain will not be responsible for workers compensation, general or professional liability insurance for any non- Intermountain provider or non-Intermountain Worker.

The Employer and Intermountain will, to the extent allowable by law, indemnify and hold each other harmless from all costs related to claims, reasonable attorney fees and costs, judgments, and settlements resulting from the negligent acts of either party.

_____ _____

Employer Representative (print name) Date

_____ _____

Employer Representative (signature) Date

Verification of Worker Requirements

The following must be verified by Employer prior to Worker's work assignment.

1) Licensure/Certification/Accreditation/Registration ☐ Yes ☐ No, Clarify: _____
_____
☐ N/A (non-clinical role)

2) Health Provider or Professional Rescuer BLS ☐ Yes, Expiration Date: _____
Intermountain-approved certification required ☐ N/A (non-clinical role)

3) Required Orientation Completed (attached):
- Intermountain Orientation ☐ Yes (mandatory)
Contingent Worker packet and Department Orientation
- Role-specific / Skills Assessment ☐ Yes (mandatory for clinical role)
Provided by Intermountain ☐ N/A (non-clinical role)

4) Background and Health Screening in accordance with Intermountain policy:

✓	Required	Completion Date	Verified By
	Urine Drug Screen • *SAM-5 urine screen is required if the worker is not providing patient care* • *SAM-9 urine screen is required if the worker is providing patient care or has direct patient contact*	*Circle test completed* SAM 5 SAM 9	
	Criminal Background Check, including OIG check, and Sex Offender Check		
	Two-Step TB Skin Test or one-time Blood Test *If positive test result, documentation of normal CXR provided by Health provider*	Step 1 _____ Step 2 _____ or Blood Test _____ If POSITIVE test: CXR_____ Medication ☐ Yes ☐ No MD clearance ☐ Yes ☐ No	
	Measles, Mumps and Rubella (MMR) *Two vaccines given at recommended intervals or laboratory evidence*	1st vaccine_____ 2nd vaccine_____ Titer_____	
	Tdap vaccine	Vaccine_____ or documentation_____	
	Varicella (Chicken Pox) *Two vaccines given at recommended intervals or laboratory evidence*	1st vaccine_____ 2nd vaccine_____ Titer_____	

Continue next page…

✓	Required	Completion Date	Verified By
	Hepatitis B Recommended if work assignment may involve exposure, or potential exposure, to blood or other potentially infectious materials *Three vaccinations and reactive tier or laboratory evidence*	1st vaccine_____ 2nd vaccine_____ 3rd vaccine_____ Titer_____ or documentation_____	
	Annual /Current Flu Vaccine		
	The following information is voluntary. If you choose not to disclose, please indicate below. *The Centers for Disease Control and Prevention (CDC) require hospitals to continue reporting COVID-19 vaccination status of all health care personnel. Your responses are voluntary but help Intermountain fulfill the CDC's requirement in reporting this information.* ☐ I choose not to disclose this information. Initial COVID-19 vaccine *Dependent upon the type of vaccine, completion of one or two vaccinations given at recommended intervals.* Vaccine manufacturer_____ Most recent booster vaccine manufacture _____	Initial vaccine: 1st vaccine_____ 2nd vaccine_____ Booster_____ *Most recent*	

_____ _____

Employer Representative (print name) Date

_____ _____

Employer Representative (signature) Date