BULLITT COUNTY PUBLIC SCHOOLS

JESSE BACON, SUPERINTENDENT
ADRIENNE USHER, ASSISTANT SUPERINTENDENT
BRANDY HOWARD, CHIEF ACADEMIC OFFICER
TROY WOOD, CHIEF OPERATIONS OFFICER

TO: Dr. Jesse Bacon, Superintendent

FROM: Dr. Lee Barger, Director CCR / Innovative Programs

DATE: September 2, 2025

RE: Memorandum of Agreement with UofL Health-South Hospital

Please see the attached Memorandum of Agreement between UofL Health-Louisville, Inc. d/b/a UofL Health - South Hospital and Bullitt County Public Schools. The purpose of this MOAis to launch and operate the Student Healthcare Experience Program (SHEP). This MOA will be in effect from September 1, 2025 - May 30, 2026.

This agreement has been reviewed by Dinsmore & Shohl LLP. Please place this request for approval on the August board agenda.

Memorandum of Agreement (MOA) Between UofL Health – Louisville, Inc. d/b/a UofL Health - South Hospital and Bullitt County Public Schools

Effective Date: September 1, 2025 **Term:** September 1, 2025 – May 30, 2026

I. Purpose

This MOA establishes a collaborative agreement between UofL Health – South Hospital ("UofL Health") and Bullitt County Public Schools ("BCPS") to launch and operate the Student Healthcare Experience Program ("SHEP"). The program is designed to provide selected high school students with paid internship opportunities in various healthcare roles to foster workforce development and career pathways in the medical field.

II. Goals and Objectives

- Create a talent pipeline for allied health professions in Bullitt County.
- Support professional and educational development of local high school students.
- Strengthen relationships among UofL Health and BCPS.
- Facilitate transition of SHEP graduates into healthcare roles with UofL Health or other regional partners.

III. Program Scope

- Cohort Size: Up to 6 students
- Duration: 32 weeks (academic year), excluding holidays and scheduled school breaks
- Weekly Commitment: ~15 hours per student
- Compensation: $15/hour with associated academic-year benefits

IV. Student Eligibility

- Enrolled in BCPS co-op program.
- Minimum 2.5 GPA
- Completion of CPR certification (AHA or Red Cross)
- Submission of recommendation letter and personal essay
- Up-to-date immunization and TB testing records
- Successful completion of all pre-hire/onboarding requirements to include 10-panel drug screen, background check, and post-offer health assessment.
- Reliable transportation

V. Responsibilities

UofL Health South Hospital:

- Conduct student selection and notification.

- Provide job descriptions, mentor matching, and workplace orientation.
- Host weekly check-ins with student interns.
- Monitor progress and document learning outcomes.
- Offer priority job interviews and employment opportunities upon completion of SHEP, in accordance with all laws, regulations, and UofL Health policies and procedures regarding hiring practices and employment.
- Provide access to tuition-free education for students hired into benefit-eligible roles in accordance with UofL Health policy.
- Maintain student intern accounts in its Workday system to record hours worked and remit payment for such hours worked.
- Submit quarterly invoices for the student intern stipends and benefits to BCPS based on the number of hours worked for the current quarter.
- Retain full responsibility for the care of its patients.

Bullitt County Public Schools:

- Identify and recommend eligible students.
- Coordinate with UofL Health staff to support interns.
- Provide oversight and academic accountability throughout the internship.
- Ensure that each intern (and their legal guardian) is provided with and completes the student paperwork:
    - Patient Confidentiality Statement attached hereto as Exhibit A
    - Statement of Understanding attached hereto as Exhibit B
    - Consent to Treat Minor Patient (Pre-Employment) attached hereto as Exhibit C
    - Agreement, Authorization, and Consent for Release of Background Information, attached hereto as Exhibit D
- Notify student interns of the requirement to wear attire appropriate for their particular experience, including personal protection equipment and identification, and conform to the standards and practices established by UofL Health South Hospital for health and other professionals.

General Agreement of the Parties:

- Neither UofL Health South Hospital nor BCPS shall discriminate on the basis of race, color, religion, national origin, marital status, disability, gender, sexual orientation, age, or political affiliation.
- Schedules shall be in accordance with BCPS's curriculum and UofL Health's standard operating procedures.
- Student Interns shall have no claim under this MOA or otherwise against UofL Health South Hospital for unemployment compensation, vacation pay, sick leave, retirement benefits, Social Security benefits, disability insurance benefits, unemployment insurance benefits, or any other benefits.

VI. Funding and Budget

- Intern stipends (hourly pay): $43,200

- Intern benefits (costs incurred by UofL Health in employing the student interns, such as payroll tax and workers comp insurance): $8,860.00
- **Total program budget:** $51,840.00 (subject to adjustment based on final cohort size and role requirements)
- Funded through partnership with Kentuckiana Works, for which a separate agreement has been entered into between UofL Health – Louisville, Inc. and Kentuckiana Works.

VII. Evaluation

- Pre- and post-internship surveys
- Analysis of student outcomes, retention, and employment impact
- Collection and dissemination of program metrics for replication potential

VIII. Agreement & Signatures

This MOA represents the mutual agreement between UofL Health – Louisville, Inc., and BillittCounty Public Schools. The parties acknowledge their shared commitment to creating meaningful learning and career opportunities for students in healthcare.

UOFL HEALTH – LOUISVILLE, INC.

By: _____
Ken Marshall
Chief Operating Officer

Date: _____

BULLITT COUNTY PUBLIC SCHOOLS

By: _____
Name:
Title:

Date: _____

Exhibit A

PATIENT CONFIDENTIALITY STATEMENT

Federal and state laws and regulations require UofL Health, Inc., on behalf of itself and its affiliates and their related practices and facilities, including, without limitation (i) University of Louisville Physicians, Inc., (ii) UofL Health-Louisville, Inc. (including Jewish Hospital, Mary and Elizabeth Hospital, Peace Hospital, Frazier Rehab Institute, Rudd Hearth and Lung Center, Abraham Flexner Outpatient Center, Medical Center East, Medical Center South, Medical Center Northeast, Medical Center), (iii) UofL Health-Shelbyville, Inc., and (iv) University Medical Center, Inc. (including University Hospital and the Brown Cancer Center) (collectively, "UofLH") to protect patient information, to train its workforce (including students and volunteers) about patient confidentiality, and to require its vendors and contracted laborers to agree to certain restrictions on the use and disclosure of patient information. While these laws and regulations cover all patients (even those who have died), there are specific restrictions on information related to AIDS/HIV status, mental health, chemical dependency, and alcoholism.

Using patient information improperly or disclosing patient information (releasing it to persons or entities outside of UofLH) improperly might result in criminal charges for, among other things, identity theft or fraud, as well as for violations of the Health Insurance Portability and Accountability Act ("HIPAA") or the Federal Law on Confidentiality of Substance Abuse Patient Records and the regulations relating to these statutes. Such improper use and/or disclosure may take any communicative or transmissive form, including but not limited to oral/verbal/spoken, written, signaled, photographic, or electronic communication/transmission of any kind, including but not limited to e-mail, text messaging, paging, social networking sites, blogs and any other internet posting and/or electronic storage media. Persons convicted of a criminal charge relating to misuse or improper disclosure of patient information face monetary penalties or imprisonment and may be required to compensate the victim.

Using patient information improperly or disclosing patient information improperly may also result in a lawsuit alleging, among other things, invasion of privacy, defamation (harming the reputation), libel, or slander. Such improper use and/or disclosure may take any communicative or transmissive form, including but not limited to oral/verbal/spoken, written, signaled, photographic, or electronic communication/transmission of any kind, including but not limited to e-mail, text messaging, paging, social networking sites, blogs and any other internet posting and/or electronic storage media.

In addition to the legal concerns surrounding the misuse or inappropriate disclosure of patient information, the core commitments of UofLH require that all patients be treated with respect, and have their privacy protected in accordance with applicable laws and with UofLH policies. All

employees, students, vendors, volunteers, and contracted laborers are therefore held accountable for the observation of applicable laws and UofLH policies concerning patient information (including account information). Each employee, student, vendor, volunteer, and contracted laborer is expected to maintain the confidentiality of patient information even after his/her relationship with UofLH ends.

Breach of confidentiality is defined as unauthorized use, discussion or release of confidential information regarding patients, their identity, and/or their medical or financial records (hard copy and computer). This includes unauthorized retrieval of records on computers or other devices, checking labs or other data without a need to do so, and conversations or discussions that may be overheard by unauthorized persons. Such improper use and/or disclosure may also take any other communicative or transmissive form, including but not limited to oral/verbal/ spoken, written, signaled, photographic, or electronic communication/ transmission of any kind, including but not limited to e-mail, text messaging, paging, social networking sites, blogs and any other internet posting and/or electronic storage media.

Breach of confidentiality is considered a major offense at UofLH. A breach of confidentiality justifies immediate termination of employee, student, vendor, volunteer, or contracted laborer status without regard to such person's length of service or prior record or conduct.

By signing below, I certify that I understand the importance of maintaining patient confidentiality and that I agree to abide by the privacy and security policies and procedures adopted by UofLH. I further certify that I have received training on HIPAA's privacy and security rules. I understand that my status as a student participant in experiences at UofLH may be terminated immediately for breach of patient confidentiality.

By signing this Statement, the undersigned agrees to be bound by the terms hereof and acknowledges his/her understanding that any breach of this Statement shall subject the undersigned to legal action by UofLH, including a claim for recovery of all losses, damages, claims, and expenses (including reasonable attorneys' fees) relating to breach of this Statement.

Signature Page Follows

To be signed by both student **and** legal guardian if student is a minor.

Student Printed Name:	
Student Signature:	
Date:	

As the legal guardian of the student named above, I agree to the above conditions.

Guardian Printed Name:	

Guardian Signature:	
Date:	

Exhibit B

STATEMENT OF UNDERSTANDING

Student Name:	
School District:	Bullitt County Public Schools
Program:	Student Healthcare Experience Program ("Program")

As a student intern of this Program, I agree to the rules, regulations, policies and procedures as stated below.

1. The Program provides a period of assigned, guided experiences at UofL Health, Inc., its affiliates and their related practices and facilities, including, without limitation, (i) University of Louisville Physicians, Inc., (ii) UofL Health-Louisville, Inc. (including Jewish Hospital, Mary and Elizabeth Hospital, Peace Hospital, Frazier Rehab Institute, Rudd Hearth and Lung Center, Abraham Flexner Outpatient Center, Medical Center East, Medical Center South, Medical Center Northeast, Medical Center), (iii) UofL Health-Shelbyville, Inc., and (iv) University Medical Center, Inc. (including University Hospital and the Brown Cancer Center) (collectively, "Hospital").

2. I will become familiar with Hospital and its policies and procedures prior to commencement of my experiences in the Hospital's practices and facilities.

3. I will complete an orientation to, and comply with, standards of conduct, rules, regulations, policies and procedures established by Hospital. In addition, I will complete the general orientation and training (including training on bloodborne pathogens, fire safety, confidentiality, abuse/neglect and operating room orientation (if applicable)) provided by Hospital and I will satisfy all requirements and testing, if any, reasonably requested by Hospital.

4. I am participating in this program as a paid intern. I will be paid an hourly rate of $15. I shall have no claim under this Agreement or otherwise against Hospital for unemployment compensation, vacation pay, sick leave, retirement benefits, Social Security benefits, disability insurance benefits, unemployment insurance benefits, or any other benefits.

5. I understand the educational experiences and knowledge gained during the Program do not entitle me to employment or any position whatsoever, or preference for employment or any position whatsoever, with Hospital.

6. It is understood I will be a student intern within Hospital's practices and facilities and will conduct myself accordingly. I will wear attire appropriate for my particular experience, including personal protection equipment and identification, and conform to the standards and practices established by Hospital for health and other professionals.

7. I will immediately notify Hospital of any illness, emergency or other cause giving rise to an unexpected absence from the training, clinical, educational or observational experience, as applicable.

8. I will use and enjoy Hospital's property and premises in an efficient, non-wasteful and professional manner.

9. I will ensure that School District has on file my personal medical history and proof of current immunity as required by Hospital at least fourteen (14) days prior to the commencement of my internship at Hospital. All such immunization and related health screenings shall be at my own expense (if applicable). I will provide evidence of satisfaction of these requirements to Hospital upon request.

10. I will agree to obtain all additional health screenings, immunizations, criminal and/or professional background checks, and drug screenings as required by Hospital.

11. I agree to adhere to School District's policies, rules, and regulations related to School District's program(s).

12. I understand that information regarding a patient or former patient is confidential and may be used only for clinical purposes within an educational setting according to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

13. I will complete the same training offered by Hospital to its full time employees regarding the privacy and security of health information and will abide by all of Hospital's policies and procedures relating to the privacy and security of health information. In that regard, all business, financial, legal, medical, and personal information disclosed by Hospital, either intentionally or unintentionally, to me in connection with this Agreement shall be held in strict confidence and shall not be disclosed by me without the prior written consent of Hospital. I shall comply with all patient confidentiality laws, including those imposed by HIPAA. I agree to take extraordinary precautions to prevent the misuse or disclosure of such confidential information. During the term and after termination of this Agreement, I shall not use any information gained as a result of this Agreement to the competitive disadvantage of, or in any other way detrimental to Hospital, its affiliates or its patients.

14. I certify that I have never been terminated from employment with Hospital, or any affiliate thereof, at any time prior to the date below.

15. I understand any action on my part inconsistent with the above understandings may result in suspension or termination of my internship. I understand that Hospital has the right to refuse or summarily terminate my participation in the Program.

Signature Page Follows

I have read and understand each term above and agree to abide by this statement of understanding.

To be signed by both student **and** legal guardian if student is a minor.

Student Printed Name:	
Student Signature:	
Date:	

As the legal guardian of the student named above, I agree to the above conditions.

Guardian Printed Name:	
Guardian Signature:	
Date:	

Exhibit C

CONSENT TO TREAT MINOR PATIENT (Pre-Employment)

UofL Health requires a health assessment and drug screen for employment. Kentucky law requires consent of parent/legal guardian for medical care of individuals under the age of 18. Therefore, if your child is employed at UofL Health prior to their eighteenth birthday, you must complete and return the following consent for the Post-Offer Health Assessment, including 10-panel Drug Screen and any required vaccinations, to the office location listed below:

UofL Health- Employee Health and Wellness Services
UofL Hospital Parking Garage - Street Level
offices 530 South Jackson Street
Louisville, KY 40202
Phone: (502) 588-0435

Consent for Medical Treatment

I,_____(print first and last name here), am the parent/legal guardian of_____(print first and last name of minor employee),currently a minor, whose date of birth is ____/____/____.

I authorize the UofL Health to provide medical and/or mental health care to my child, including, but not limited to, diagnostic examinations (including radiological and laboratory testing), physical assessment (including lifting, pulling, bending, stretching, vision test, and color vision assessment), tuberculosis screening, verification and/or administration of immunizations and mental health counseling.

I understand that, should my child need more invasive diagnostic or surgical procedures, attempts will be made to contact me before such care is initiated.

I further understand that, once my child reaches the age of majority, my consent for treatment is no longer required.

By signing this, I acknowledge that I have read and that I understand this consent, and that any questions I had prior to signing, could be answered by calling UofL Health - Employee Health and Wellness Services at (502) 588-0435.

_____ _____
Signature Date

Emergency contact number:

(____)_____-_____

Exhibit D

AGREEMENT, AUTHORIZATION, AND CONSENT FOR RELEASE OF BACKGROUND INFORMATION

PLEASE TYPE OR PRINT

I,_____,
LAST NAME FIRST NAME MIDDLE NAME (PLEASE INCLUDE Jr, Sr, II III, etc)

the parent or legal guardian of_____understand that in conjunction with my child's application for employment, work to be performed under contract, promotion, volunteer position, reassignment, and/or retention ("Work"), **UofL Health** will use the services of an outside agency to research and verify the information they have provided on the application for employment including personal background, character, professional standing, work history and qualifications. This agency will provide a written report of its findings to **UofL Health. UofL Health** uses **Universal Background** as an agent to perform its Employment-related background investigations.

For this type of employment, State law requires a State and National criminal history background check as a condition of employment. With this authorization form, **UofL Health** is requesting a state and national criminal history background check (House Bill 3, Section 19, KY GA 2006 session).

Universal Background will utilize various sources of information it deems appropriate including but not limited to: criminal conviction records, current and former employers, department of motor vehicle records, military records, credit reporting agencies, education records, professional and personal references and workers compensation records including any and all injuries in compliance with the Americans with Disabilities Act. I agree, authorize, and consent to the release and disclosure of any and all information including but not limited to the above to **UofL Health** and **Universal Background**.

I agree, authorize, and consent to the procurement of a Consumer Report and/or an Investigative Consumer Report and understand that it may contain information about their credit worthiness, credit standing, credit capacity, character, general reputation, personal characteristics, or mode of living. This authorization in original or copy form shall be valid for term of their Work from the date indicated next to my signature. According to the Fair Credit Reporting Act, I will be notified by **UofL Health** if Work is denied because of information obtained from a Consumer Reporting Agency. Additionally, I understand that if requested within 60 days, I will be given a full and accurate disclosure as to the nature and substance of all information provided to **UofL Health.** I further understand that I may request a copy of the report, and that when doing so, proper identification will be required and I should direct my request to: **Universal Background Screening, PO Box 5920, Scottsdale, AZ 85261.** I understand that residents of all states will automatically receive a copy of the report if an adverse action is taken regarding the employment application, or upon request as outlined herein.

INFORMATION FOR PROCESSING OF BACKGROUND SCREEN REPORT ONLY (to be used for no other purposes)

_____ ___/___/___ ___-___-___
MINOR CHILD'S NAME AS IT APPEARS ON BIRTH CERTIFICATE DATE OF BIRTH SOCIAL SECURITY NUMBER

Addresses:
Please provide previous two addresses in the past seven years:

Current Address: _____
STREET APT # CITY STATE ZIP CODE

Former Address: _____
STREET APT # CITY STATE ZIP CODE

Alias Names:
Please list other names used in the past 10 years:

_____
LAST NAME FIRST MIDDLE SUFFIX

_____
LAST NAME FIRST MIDDLE SUFFIX

_____ _____
SIGNATURE OF PARENT OR LEGAL GUARDIAN