C-18-0356

CONTRACT DOCUMENTS

CITY OF LINCOLN
NEBRASKA

Annual Services
Employee Medical Exams

Company Care
5000 N. 26th Street, Suite 200
Lincoln, NE 68521
(402) 475-6656

CITY OF LINCOLN
CONTRACT TERMS

THIS CONTRACT, made and entered into by and between **Company Care, 5000 N. 26th St, Suite 200, Lincoln, NE 68521**, hereinafter called "Contractor", and the City of Lincoln, Nebraska, a municipal corporation, hereinafter called "Owners".

WHEREAS, the Owner has caused to be prepared, in accordance with law, Specifications, Plans, and other Contract Documents for the Work herein described, and has approved and adopted said documents and has sought proposals for and in connection with said Work, to-wit:

Employee Medical Exams

and,

WHEREAS, the Contractor, in response to such request, has submitted to the Owners, in the manner and at the time specified, a sealed Proposal/Supplier Response in accordance with the terms of said request; and,

WHEREAS, the Owners, in the manner prescribed by law has opened, examined, and canvassed the Proposals/Supplier Responses submitted in response to such request, and as a result of such canvass has determined and declared the Contractor to be the lowest responsible bidder for the said Work for the sum or sums named in the Contractor's Proposal/Supplier Responses, a copy thereof being attached to and made a part of this Contract;

NOW, THEREFORE, in consideration of the sums to be paid to the Contractor and the mutual covenants herein contained, the Contractor and the Owners have agreed and hereby agree as follows:

1. The Contractor agrees to (a) furnish all tools, equipment, supplies, superintendence, transportation, and other accessories, services, and facilities; (b) furnish all materials, supplies, and equipment specified to be incorporated into and form a permanent part of the complete work; (c) provide and perform all necessary labor in a substantial and workmanlike manner and in accordance with the provisions of the Contract Documents; and (d) execute and complete all Work included in and covered by the Owners award of this Contract to the Contractor, such award being based on the acceptance by the Owner of the Contractor's Proposal, or part thereof, as follows:

   Agreement to full proposal

2. The Owner agrees to pay to the Contractor for the performance of the Work embraced in this Contract, the Contractor agrees to accept as full compensation therefore, the following sums and prices for all Work covered by and included in the Contract award and designated above, payment thereof to be made in the manner provided by the Owners:

   The Owners will pay for products/service, according to the Line Item pricing as listed in Contractors Proposal/Supplier Response, a copy thereof being attached to and made a part of this Contract. The Owners shall order on an as needed basis for the duration of the contract. The estimated cost of products or services for City departments shall not exceed $98,000 during the contract term. The

estimated cost of products or services for County agencies shall not exceed $16,500 during the contract term without approval of the Board of Commissioners.

3. Equal Employment Opportunity: In connection with the carrying out of this project, the contractor shall not discriminate against any employee or applicant for employment because of race, color, religion, sex, national origin, ancestry, disability, age or marital status. The Contractor will take affirmative action to ensure that applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex, national origin, ancestry, disability, age or marital status. Such action shall include, but not be limited to, the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other compensation; and selection for training, including apprenticeship.

4. E-Verify: In accordance with Neb. Rev. Stat. 4-108 through 4-114, the contractor agrees to register with and use a federal immigration verification system, to determine the work eligibility status of new employees performing services within the state of Nebraska. A federal immigration verification system means the electronic verification of the work authorization program of the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, 8 U.S.C. 1324 a, otherwise known as the E-Verify Program, or an equivalent federal program designated by the United States Department of Homeland Security or other federal agency authorized to verify the work eligibility status of a newly hired employee pursuant to the Immigration Reform and Control Act of 1986. The Contractor shall not discriminate against any employee or applicant for employment to be employed in the performance of this section pursuant to the requirements of state law and 8 U.S.C.A 1324b. The contractor shall require any subcontractor to comply with the provisions of this section.

5. Termination: This Contract may be terminated by the following:
   - 5.1) Termination for Convenience: Either party may terminate this Contract upon thirty (30) days written notice to the other party for any reason without penalty.
   - 5.2) Termination for Cause: The Owners may terminate the Contract for cause if the Contractor:
     - 5.2.1) Refuses or fails to supply the proper labor, materials and equipment necessary to provide services and/or commodities.
     - 5.2.2) Disregards Federal, State or local laws, ordinances, regulations, resolutions or orders.
     - 5.2.3) Otherwise commits a substantial breach or default of any provision of the Contract Document. In the event of a substantial breach or default the Owners will provide the Contractor written notice of said breach or default and allow the Contractor ten (10) days from the date of the written notice to cure such breach or default. If said breach or default is not cured within ten (10) days from the date of notice, then the contract shall terminate.

6. Independent Contractor: It is the express intent of the parties that this contract shall not create an employer-employee relationship. Employees of the Contractor shall not be deemed to be employees of the Owners and employees of the Owners shall not be deemed to be employees of the Contractor. The Contractor and the Owners shall be responsible to their respective employees for all salary and benefits. Neither the Contractor's employees nor the Owners' employees shall be entitled to any salary, wages, or benefits from the other party, including but not limited to overtime, vacation, retirement benefits, workers' compensation, sick leave or injury leave. Contractor shall also be responsible for maintaining workers' compensation insurance,

unemployment insurance for its employees, and for payment of all federal, state, local and any other payroll taxes with respect to its employees' compensation.

7. Owner Inclusion. It is understood and agreed by all parties that "Owner/s" shall include the City of Lincoln and Lancaster County, Nebraska. Whenever in the Contract documents, including the instructions to bidders, specifications, insurance requirements, bonds and terms and conditions or any other documents which are a part of the Contract, a singular entity is referenced (i.e. "the City" or "the County") it shall mean the "Owners" encompassing the City of Lincoln, and Lancaster County. Notwithstanding the foregoing, the duties and obligations of the City, the County, and the Building Commission pursuant to the Contract shall be treated as divisible and severable duties and obligations, and default by any one of the City, the County or the Building Commission shall not be attributed to any other of the Owners, but shall remain the sole obligation of the defaulting entity.

8. Period of Performance: This Contract shall be effective upon execution by both parties. The term of the Contract shall be a one (1) year term, with option for three (3) additional one (1) year terms.

9. The Contract Documents comprise the Contract, and consist of the following:
   1. Contract Terms
   2. Accepted Proposal/Supplier Response
   3. Addendums (if any, list numbers)
   4. Special Provisions (if applicable
   5. Specifications
   6. Instructions to Bidders
   7. Insurance Requirements
   8. Sales Tax Exemption Form 13
      (Note: This form cannot be used for the WATER Division of the City of Lincoln. The WATER Division is taxable per Reg. 066.14A or applicable laws.)

The herein above mentioned Contract Documents form this Contract and are a part of the Contract as if hereto attached. Said documents which are not attached to this document may be viewed at: lincoln.ne.gov - Keyword: Bid - Awarded or Closed bids.

The Contractor and the Owners hereby agree that all the terms and conditions of this Contract shall be binding upon themselves, and their heirs, administrators, executors, legal and personal representatives, successors, and assigns.

IN WITNESS WHEREOF, the Contractor and the Owners do hereby execute this contract upon completion of signatures on:

Vendor Signature Page
City of Lincoln Signature Page
Lancaster County Signature Page

Vendor Signature Page

CONTRACT
Employee Medical Exams
Company Care/The Physician's Network

EXECUTION BY CONTRACTOR

IF A CORPORATION:

Attest:

Lincoln Physician Group LLC
Name of Corporation DBA Company Care

______________________ Seal
Secretary

2000 Q Street, Lincoln Ne 68503.
Address

By: Barry Hoover MD
Duly Authorized Official

President
Legal Title of Official

IF OTHER TYPE OF ORGANIZATION:

The Physician Network
Name of Organization

Company Care
Type of Organization

5000 N. 26th #200, Lincoln, 68521
Address

By: ______________________
Member

By: ______________________
Member

IF AN INDIVIDUAL:

____
Name

____
Address

____
Signature

City of Lincoln Signature Page

CONTRACT
Employee Medical Exams
Company Care/The Physician's Network

EXECUTION BY THE CITY OF LINCOLN, NEBRASKA

ATTEST:

____
City Clerk

CITY OF LINCOLN, NEBRASKA

____
Chris Beutler, Mayor

Approved by Executive Order No.________________

dated ____________________________________

Lancaster County Signature Page

CONTRACT
Employee Medical Exams
Company Care/The Physician's Network

EXECUTION BY LANCASTER COUNTY, NEBRASKA

ATTEST:

____
Deputy Lancaster County Attorney

THE BOARD OF COUNTY COMMISSIONERS OF
LANCASTER COUNTY, NEBRASKA

____

____

____

____

____

dated ______________________________

SPECIFICATIONS FOR
EMPLOYEE MEDICAL EXAMS

1. INTENT / GENERAL INFORMATION

1.1 The City of Lincoln, hereinafter referred to as the City, seeks proposals from qualified medical practitioners to provide annual Employee Medical Exams.

1.2 The proposal should detail the medical expert's occupational health exam experience.

1.3 A qualified medical practitioner is defined for this purpose to be one that practices in a medical profession with an examination staff that are medical doctors.

1.4 Vendors must submit a written proposal which will be received in the City of Lincoln/Lancaster County Human Resource Office prior to
April 23, 2018 at 12:00 p.m.

- 1.4.1 Proposals received after the specified day and hour will be considered null and void and will not be accepted.
- 1.4.2 Proposals shall be submitted in a sealed envelope clearly indicating the "Employee Medical Exams " and your company name.

1.5 All inquiries regarding these specifications shall be directed to Bob Nemecek, Safety & Training Coordinator at rnemecek@lincoln.ne.gov or faxed to: 402-441-6800.

1.6 Proposals must remain firm for ninety (90) days from the proposal due date.

- 1.6.1 The City of Lincoln reserves the right to refuse any or all proposals and to waive technicalities in order to accept proposals that may be in the best interest of the City of Lincoln, as its sole discretion.

1.7 The proposer's response must clearly present the proposer's compensation of fee structure for specified core services, along with rates for optional services available.

2. SCOPE OF THE WORK

2.1 While the exact range and extent of services is subject to negotiation, it is anticipated that the selected medical practitioner shall provide, as a minimum, professional services and dedicated personnel necessary to perform the following:

- 2.1.1 Develop a complete understanding of the City's areas of exposure and consult with City representatives about goals and objectives of the annual Employee Medical Exam.
- 2.1.2 If necessary; prepare a kick-off meeting to introduce and carry out the campaign objectives.
- 2.1.3 Provide physical exams for on duty personnel.
  - 2.1.3.1 It is estimated that exams will be required for 250 - 350 employees annually.
  - 2.1.3.2 Develop an annual exam calendar with this program targeted to begin as soon as possible
  - 2.1.3.3 Outline a program for a 12 month period with additional long range planning for an on-going campaign
  - 2.1.3.4 **Medical Exam Elements**:
    - 2.1.3.4.1 In-depth Medical History
    - 2.1.3.4.2 Blood Pressure/Pulse (Resting)
    - 2.1.3.4.3 Blood Pressure/Pulse (Activity, i.e. Treadmill)
    - 2.1.3.4.4 Height/Weight
    - 2.1.3.4.5 Vision/Color
    - 2.1.3.4.6 Audiometric
    - 2.1.3.4.7 Urinalysis

2.1.3.4.8 EKG
2.1.3.4.9 Respiratory Clearance (PFT)

2.1.3.5 CHEM PROFILE
- 2.1.3.5.1 Glucose
- 2.1.3.5.2 Uric Acid
- 2.1.3.5.3 Bun
- 2.1.3.5.4 Creatinine
- 2.1.3.5.5 BUN/Creatinine Ratio
- 2.1.3.5.6 Sodium
- 2.1.3.5.7 Potassium
- 2.1.3.5.8 Chloride
- 2.1.3.5.9 Osmolality (calculation)
- 2.1.3.5.10 Calcium
- 2.1.3.5.11 Phosphorus
- 2.1.3.5.12 Protein, total
- 2.1.3.5.13 Albumin
- 2.1.3.5.14 Globulin
- 2.1.3.5.15 A/G ratio
- 2.1.3.5.16 Bilirubin, total
- 2.1.3.5.17 LDH
- 2.1.3.5.18 SGOT (AST)
- 2.1.3.5.19 SGPT (ALT)
- 2.1.3.5.20 GGT
- 2.1.3.5.21 Iron, total

2.1.3.6 LIPID PROFILE, Cholesterol, total
- 2.1.3.6.1 Triglycerides
- 2.1.3.6.2 HDL Cholesterol (calculated)
- 2.1.3.6.3 VLDL Cholesterol (calculated)
- 2.1.3.6.4 LDL/HDL ratio
- 2.1.3.6.5 Total Cholesterol/HDL ratio estimated CHD risk

2.1.3.7 THYROID PROFILE T_4 (Thyroxine)
- 2.1.3.7.1 T_3 uptake
- 2.1.3.7.2 Free Thyroxine

2.1.3.8 HEMATOLOGY PROFILE CBC
- 2.1.3.8.1 Platelet Count
- 2.1.3.8.2 Differential

2.1.3.9 IMMUNIZATIONS (optional)
- 2.1.3.9.1 Hepatitis B
- 2.1.3.9.2 Tetanus
- 2.1.3.9.3 Influenza

2.1.3.10 REPORTING & RECORDS
- 2.1.3.10.1 Provide Employee with a summary report.
- 2.1.3.10.2 Provide Employees Designated Physician with a report, if desired.
- 2.1.3.10.3 Immediately Advise the employee's City Department Head and the Human Resources Director of anyone unfit to perform their assignment due to medical condition.
  - 2.1.3.10.3.1 This shall include a review of the employee's job description to determine their fitness for duty to complete all responsibilities of the job including law enforcement, fire or transportation duties, etc. under current applicable state and federal regulatory guidelines.

2.1.3.10.4 **Keep <u>CONFIDENTIAL</u> records for all employees.**

2.1.3.10.4.1 This shall include the appropriate OSHA mandated storage of medical records.

2.1.3.10.4.2 Please attach a copy of your medical records retention policy to your proposal.

2.1.3.10.5 Acquire all existing medical records from last healthcare provider and maintain until the contract for service ends or it is transferred to a new vendor.

2.2 All reports, examination results and correspondence must be accomplished in a timely manner.

2.2.1 Accuracy of all this information is of highest priority so as to eliminate any costly hiring errors for the City.

2.2.2 There are many different types of examinations required and it is up to the provider to keep them separate and marked accordingly.

3. <u>TERM OF CONTRACT/TERMS</u>

3.1 The initial term of the qualified medical practitioner contract shall be for a period of one (1) year, renewable by mutual consent on an annual basis thereafter for no more than three (3) additional one year terms.

3.2 The contract may be terminated by either party by giving the other party written notice of such intent not less than ninety (90) days prior to the effective date of the termination.

3.3 In the event of termination, compensation owed the medical practitioner by the City shall be limited to verifiable services rendered.

3.4 All medical records shall be transferred to the new provider if either party ends the contract.

3.5 At the time of award by the City, the apparent successful proposers must have agreed to a contract representing the understandings between the parties as to terms and conditions which will govern the relationship and establish the obligations of each party for performance of the agreement.

3.6 The proposer shall be aware that the contents of the successful proposal will become a part of the subsequent contractual documents.

4. <u>GENERAL CONDITIONS</u>

4.1 Legal Compliance

4.1.1 Each proposer is responsible for full and complete compliance with all applicable laws, rules, regulations and licensing requirements imposed by any public authority having jurisdiction.

4.2 Proposer's Insurance

4.2.1 The medical practitioner must provide and maintain in force at all times, should they be the successful proposal, insurance for Medical Professional Liability in the amount of a $2,000,000, naming the City of Lincoln as an additional insured.

4.2.2 Other necessary insurance coverages include Workers' Compensation, General Liability and Automobile Liability Insurance.

4.2.3 Such policies shall be issued by companies authorized to do business in the State of Nebraska.

4.2.4 Evidence of such coverage is to be submitted as part of the proposal.

4.3 Non-Discrimination

4.3.1 The medical practitioner shall not discriminate or permit discrimination in its operations or employment practices against any person or group on the grounds of race, color, creed, national origin, gender or handicaps, and shall furnish evidence of compliance with this provision when so

requested by the City.

4.4 Indemnification

4.4.1 The medical practitioner, in performing its obligations under this contract, is acting independently and the City assumes no responsibilities or liability for the medical practitioner's acts or omissions to third parties.

4.4.1.1 The medical practitioner shall agree to indemnify and hold harmless the City, its officials, officers, and employees against any and all claims, lawsuits, judgements, costs and expenses for which recovery of damages is sought, suffered by any person or persons, that may arise out of or be occasioned by the medical practitioner's breach of the terms or provisions of the contract, or by any negligent act or omission of the medical practitioner's performance of this contract; except that the indemnity specified in this paragraph shall not apply to any liability resulting in the sole negligence of the City, its officials, officers or employees.

4.4.2 In the event of joint and concurrent negligence of both the practitioner and the City, responsibility and indemnity, if any, shall be apportioned comparatively in accordance with the laws of the State of Nebraska; without, however, waiving any governmental immunity available to the City of Lincoln under Nebraska law and without waiving any defense of the parties under Nebraska law.

4.4.3 This above paragraph is solely for the benefit of the medical practitioner and the City and is not intended to create or grant any right, contractual or otherwise, to any other person or entity.

4.4.4 The agreement resulting here-from must contain language stating that the contract is performed in Lancaster County, and shall be construed in accordance with the laws of the State of Nebraska; if any legal action is brought in connection with enforcement of the contract, exclusive venue shall lie in Lincoln, Nebraska.

5. PROPOSALS SHOULD INCLUDE THE FOLLOWING:

5.1 Executive Summary

5.1.1 Prefacing the proposal shall be an Executive Summary of three (3) pages or less, providing in concise terms a summation of the proposal and bearing the signature of the medical practitioner.

This summary shall include the following:

5.1.1.1 Location of the medical examination facility

5.1.1.2 Number of examination rooms and special medical equipment available

5.1.1.3 Medical examination team that will examine employees and the Curriculum Vitae of all staff

5.1.1.4 Your policy regarding the release of information and your records retention policy

5.1.1.5 Available office hours for examinations

5.1.1.6 Methods of records transmission, retention and accessibility

5.1.1.7 Overall philosophy or approach used by your firm

5.1.1.8 Examination implementation plan or schedule

5.1.1.9 Detailed cost for examination services and costs for additional ancillary services

5.1.1.10 Will there be additional PPO or other discounts provided

5.1.1.11 Recent experience with other examination services

5.1.1.12 Names and contact information of 3 businesses presently utilizing your services

5.1.1.13 Please attach a copy of examination report forms

5.1.1.14 Additional pertinent information

5.1.1.15 Does your examination copy with all federal DOT and state regulatory requirements

5.2 Structure of the Proposal

5.2.1 Part I - Concept and Solution

5.2.1.1 The proposer's understanding of the tasks presented in paragraph 2 shall be defined in detail and proposed solutions outlined.

5.2.1.1.1 Full description of proposer's program

5.2.1.1.2 Plan of Work

5.2.1.1.3 Qualifications

5.2.1.1.4 Resumes of key personnel

5.2.1.1.5 Location of facilities to perform the exams.

5.2.2 Part II - Program

5.2.2.1 The proposer's technical plan to accomplish the work shall be presented.

5.2.3 Part III - Experience

5.2.3.1 Emphasis shall be given to identifying comparable services for public sector organizations.

5.2.3.2 For each client reference, the scope of service, time performed, and name, title, address and phone number of the principle contact person should be shown.

5.2.3.3 Some City departments may elect to not use all aspects of the physical exam.

5.2.3.3.1 The proposal should be divided by type of service to allow flexibility by department.

5.2.4 Part IV - Cost Proposal

5.2.4.1 The City seeks an all-inclusive cost structure which will allow predictability of fees and accuracy in budget planning.

5.2.4.2 The proposer's plan of compensation shall be described in detail.

5.2.4.3 The proposal shall include a clear statement of the services for which compensation would be provided.

5.2.4.4 If there are expenses which are considered reimbursable and are not included in the fee structure, such expenses shall be identified and quantified as fully as possible.

5.2.4.5 Proposer should be familiar with NFPA 1582 Medical Requirements for Firefighters, Police and Transit Employees and with 49CFR391.41 Physical Qualifications For Drivers.

5.2.5 Part V - Proof of Insurance

5.2.5.1 The medical practitioner must provide and maintain in force at all times, should they be the successful proposal, insurance for Medical Professional Liability in the amount of a $2,000,000 single limit policy, naming the City of Lincoln as an additional insured.

5.2.5.2 Other necessary insurance coverages include Workers' Compensation, Commercial General Liability, Automobile Liability, and Excess Insurance.

6. COMPETITIVE SELECTION

6.1 Evaluation factors outlined in Paragraph seven (7) shall be applied to all eligible, responsive medical practitioners in comparing proposals and making the final selection.

6.2 While the City reserves the right to interview any or all proposers, award of a contract may be made without discussion with proposers after proposals are received.

6.3 Proposals should, therefore, be submitted on the most favorable terms available.

7. EVALUATION OF PROPOSALS and FACTORS

7.1 Concept proposal and possible creative solution, including responsiveness to terms and conditions and the completeness and thoroughness of documentation.

7.2 Demonstration of successful prior performance of comparable services in the public or private sector.

7.3 Adequacy and technical depth of personnel assigned to the program.

7.4 Evidence of good organization and management practices.

7.5 Depth and breadth of services available.

7.6 Expertise and tenure of medical practitioner.

7.7 The ability to provide services which meet the requirements set forth in documents.

7.8 The City of Lincoln reserves the right to make such investigations as it deems necessary to determine the ability of the proposer to provide services meeting a satisfactory level of performance in accordance with the City's requirements.

7.9 Proposers shall furnish such information and data for this purpose as the City may request.

7.10 Interviews and/or presentations by one, several or all of the proposers may be requested by evaluators if deemed necessary to fully understand and compare proposer's capabilities.

8. PROPOSED TIME SCHEDULE (tentative)

8.1	Send out request	April 13, 2018
8.2	Receive proposals	April 23, 2018
8.3	Selection Committee Review	April 25, 2018
8.4	Award of Contract	As soon as possible

The Physician Network

Company Care
5000 North 26th Street
Suite 200
Lincoln, NE 68521

P 402.475.6656
F 402.742.8419
companycareonline.com

PROPOSAL FOR
EMPLOYEE MEDICAL EXAMS 4/13/18

BOB NEMECEK
SAFETY AND TRAINING COORDINATOR
CITY OF LINCOLN
555 S. 10TH STREET, ROOM 302
LINCOLN, NE 68508

FROM:
Company Care
5000 N. 26th Suite 200
Lincoln, NE 68521
(402) 475-6656

April 17, 2018
{L0683337.3}

The Physician Network

Company Care
5000 North 26th Street
Suite 200
Lincoln, NE 68521

P 402.475.6656
F 402.742.8419
companycareonline.com

April 17, 2018

Bob Nemecek
Safety & Training Coordinator
City of Lincoln
555 S. 10th, Room 302
Lincoln, NE 68508

Re: Proposal for Employee Medical Exams 2018-2019 w/3 1 year auto renews

Dear Mr. Nemecek,

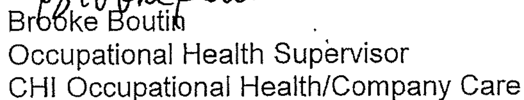
Enclosed, please find Company Care's Proposal for Employee Medical Exams submitted in response to your request for proposal.

We are eager to continue providing employee medical exams for the City of Lincoln/Lancaster County for an additional four years! We highly value the relationship we have developed with the City and County under our current contract. We believe, as Lincoln's only hospital-based occupational health program, we can continue to provide the City and County with the only comprehensive health system that is focused entirely on the needs of business and industry in the Lincoln area. Our goal is to bring all of the strengths and assets of the CHI Health-St. Elizabeth Health System which is apart of Catholic Health Initiatives to the City/County and its employees. As in the past, we will continue to focus on early detection, disease prevention, employee education and encouraging lifestyle changes to keep City and County employees productive and on-the-job.

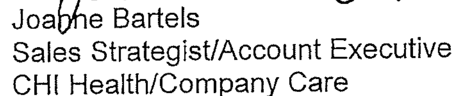
As you will see in this proposal and from our current contractual relationship with the City, we are committed to providing consistent and comprehensive medical evaluations for the City of Lincoln and Lancaster County employees.

Thank you for your consideration of our proposal. We look forward to continuing our partnership together.

Sincerely,



Brooke Boutin
Occupational Health Supervisor
CHI Occupational Health/Company Care



Joanne Bartels
Sales Strategist/Account Executive
CHI Health/Company Care

{L0683337.3}

5.1 EXECUTIVE SUMMARY

5.1.1 Company Care (Company Care) is submitting this proposal to the City of Lincoln/Lancaster County in response to the City's Request for Proposal dated 4/13/18, for qualified medical practitioners to provide annual Employee Medical Exams. Company Care is proposing to provide occupational medicine services to the City of Lincoln/Lancaster County for its employees.

Company Care, part of the The Physician Network and Catholic Health Initiatives, has been serving Lincoln area businesses since 1990, providing medical exams for a variety of businesses in both the public and private sector. Currently we provide occupational health services to approximately 500 companies. (See references in section 5.2.3.3 of this proposal response). Company Care currently provides employee medical exams for the City of Lincoln's fire fighters, police officers, and Star Tran employees and has done so for the past ten years. In addition, we have worked closely with the Urban Search And Rescue team to provide the necessary testing (on and off site) required by FEMA. Company Care has also provided medical exams for the Lancaster County Sheriff's Department, Lancaster County Corrections and Lancaster County Youth Services.

Except as otherwise stated in this proposal, Company Care will provide all components of the Medical Exam at our 5000 N. 26th Street Suite 200 location, Monday through Friday, between 7:00 a.m. - 5:00 p.m. Same day service can be rendered as needed. Employees can usually be seen within 24-48 hours of calling to schedule this exam. Services for special testing needs at a worksite can be made available upon request. Company Care has seven exam rooms, three drug testing stations, x-ray and lab. Additionally, an audio booth is provided for OSHA regulated hearing screens, two titmus vision screeners, breath alcohol machine, two pulmonary function testing machines and an EKG machine.

Company Care can transmit medical records via fax, email or mail and stores occupational medical exam records for 30 years (see the attached policy "Medical Records: Storage and Purging" regarding release of information and record retention in section 8).

Employees and their designated physician (if requested) will be provided with a summary report of the Medical Exam. If any employee is deemed unfit to perform their assigned duties due to a medical condition, the designated City contact will be notified immediately. Confidentiality of medical information we create or receive is our highest priority.

Company Care intends to protect the confidentiality of City employees' medical information and to abide by all applicable statutes, rules, regulations and requirements of law and medical ethics in this regard.

Company Care's staff consists of an occupational health physician and a physician assistant. Dr. David Durand, the Medical Director of Company Care, is board certified in occupational medicine and specializes in work-related musculoskeletal injuries. He is also a certified Independent Medical Examiner and a Medical Review Officer. He has a

strong occupational medicine and business background and holds both a Master in Public Health (MPH) and Master in Business Administration (MBA).
Penni Jackson, PA, has several years of occupational medicine experience with additional experience working in the emergency room at CHI Health-St. Elizabeth and with the Nebraska Heart Hospital. She has been with the Company Care team since 2012.

Dr. Durand and Ms. Jackson have experience with musculoskeletal injury treatment and back safety education, which will be included as a component of the medical exams to be provided. Their curriculum vitae are included as attachments to this proposal response.

Other team members include: Certified Occupational Health Nurses, Licensed Practical Nurses, Board Certified Ergonomist, Limited Radiology Technicians, Audiology Technicians, Certified Breath Alcohol Technicians, Certified Saliva Test Technicians, Certified Drug Screen Collection Technicians, Spirometry Technicians, Physical and Occupational Therapists, Sales Strategist/Account Executive, and Occupational Health Clinic Staff.

We have provided employee medical examinations in the past for fire, police, transit, County sheriff, corrections and County youth services and are aware of each City and County division's unique needs. If no changes in protocol for the medical examinations are desired, we are ready to move forward immediately in providing the services required upon acceptance of our proposal.

We anticipate that communication for employees should be fairly limited since many, if not most of the City's employees have been participating in these physicals for the past six years at Company Care and are or should be familiar with our clinic location. For further details regarding our anticipated communications for City employees, please see 5.2.1 Scope of Work, 2.1.2 Communication Plan.

For a detailed listing of the cost of exams and related fees see Part IV, 5.2.4.1.

5.2.1 Part 1: Concept and Solution (Scope of Work)

5.2.1.1.1 Company Care has worked with many of the City of Lincoln's and Lancaster County's representatives over the past ten years. During that time, we have established a good understanding of the health exposures facing various public sector employees, including firefighters, Urban Search And Rescue members, clandestine lab members, police officers, and transit workers. Our medical team has specialized in the area of identifying exposures, injury risks and providing medical care and treatment to increase the overall health of the City's workforce. Company Care is very familiar with DOT and NFPA 1582 medical requirements, so that our employee medical examinations will facilitate compliance with all applicable regulatory guidelines.

Our physician and physician's assistant are available to provide consultative services to ensure conformity of medical exams to regulatory guidelines. They are prepared to make the necessary phone calls and professional contacts that may be needed to obtain initial information in this regard as well.

2.1.1.2 **Communication Plan:** Company Care is willing to develop a communication plan to whatever scope or intensity the City feels is necessary or desirable under the circumstances. Company Care has worked hard over the past ten years to make sure we are meeting the needs of each City representative and the City's employees.

Employees are given a customer satisfaction survey after each visit to ensure we are meeting their needs. Completed customer satisfaction surveys are reviewed by the Medical Director and Program Manager weekly. Additionally, we have provided the Fire Department with aggregate reporting based on the outcome of their surveys.

Additionally, Company Care has dedicated a corporate account executive, Joanne Bartels, who has been with Company Care for the past 12 years to meet with the City and County representatives frequently to discuss their satisfaction with the program and to ensure we are meeting their goals and objectives.

5.2.2 Part II: The Program (The Technical Plan)

5.2.2.1 Listed below are the medical exam components specifically outlined by time allotment. This list illustrates what the City and City employees might expect when scheduling an appointment with Company Care for the medical exam.

5.2.2.1.1 Time Allotment for Medical Examinations

Scheduling:

- Employees can usually be seen within 24-48 hours of scheduling an appointment. Same day service is available if necessary.

Physical:
Nursing component to include: 30-50 minutes

- Blood pressure
- Vital signs
- Height and weight
- Vision testing
- Hearing
- Urinalysis
- Electrocardiogram (EKG)
- Pulmonary Function Testing (PFT)
- Chest x-ray
- Lab draws (chemistry, lipid, thyroid, hematology profiles)

Physician/Physician Assistant exam 30 minutes

TOTAL PHYSICAL EXAM TIME: 60-90 minutes

Reporting:

- Full report with lab results can be expected within five working days following the medical exam.
- If requested by the employee, the employee's designated physician will be provided with a summary report.
- The designated City contact will be notified immediately if the employee is deemed unfit to perform their assigned duties.

The Annual Exam Calendar

Under the current contract, Company Care has developed a plan with each City representative from fire, police and transit to fulfill the needs and scheduling guidelines for each City division receiving services from us. A sample calendar of activities is set out below.

A potential timetable may include:

Jan-June	annual fire fighter exams including USAR
Year Round	annual CLAN/SWAT
Year Round	pre-employment all departments
	annual elective exams for all police
	Star Tran employees

Sample 12-month Calendar of Activities (Revised as Needed)

First Month

- Meet with City contact to review goals, objectives and communication of results and compare to past years. We have worked with the Fire Chief and personnel to efficiently schedule the annual exams for the firefighters which has resulted in as little time out of service as possible.
- If there are no changes to a specific City division's goals, Company Care will set up an account for the City division if one has not already been established, and will then begin providing services immediately. Company Care is familiar with most, if not all of the City contacts involved that may require services under the proposal. For those City contacts served under the current contract, individual procedures for those divisions are now in place, subject to re-verification of their procedures as explained above.
- Company Care will be prepared to begin scheduling City employees upon awarding of the contract.
- Many, if not most, City employees are or should be familiar with our location and have been to our facility in the past. Maps of our location are available upon request.

Second –Twelfth Month

- Semi-annual meetings can be scheduled with City contacts or as needed to discuss and monitor customer satisfaction.
- Physicals continue to be scheduled and performed.
- Ongoing medical exams and medical reporting.

Medical Exam Elements

Except as otherwise stated in this proposal, physicals will be performed at our 5000 N. 26th, Suite 200, Monday through Friday between the hours of 7:00 a.m. - 5:00 p.m. Appointments will be scheduled in advance.

Company Care is prepared to offer 250-350 annual Medical Exams for firefighters, police, transit and/or other employees and other services as requested by the City.

Firefighter/Police/Transit/Other Employee Medical Exam may include:

- Physician/Physician Assistant exam to include:
  - In-depth medical and occupational history
  - Blood pressure/pulse resting
  - Blood pressure/pulse after activity
  - Vital signs including temperature, respirations
  - Height and weight
  - Vision testing (includes near, far, color and peripheral)
  - Urinalysis (UA)
- Audiogram
- Electrocardiogram (EKG)
- Pulmonary Function Testing (PFT)
- Respirator Questionnaire
- Chemistry profile
- Lipid profile
- Thyroid profile
- Hematology profile

The following additional medical exam elements may be ordered as needed at the discretion of the City or medical practitioner. These include, but are not limited to:

- DOT physical
- Hazmat, respirator, asbestos, lead and painters physicals
- Fit for duty evaluations
- DOT/Non-DOT drug testing
- RBC cholinesterase for pesticide exposures
- Zinc protoporphyrin
- Heavy metal panel (lead, arsenic, mercury)
- Bloodborne pathogen exposure testing
- Body composition testing
- Chest x-ray
- TB
- Cardiac treadmill or other cardiac work-up as indicated (available at Saint Elizabeth Regional Medical Center)
- Post offer/pre-confirmation/fit for duty back screens
- Ergonomic assessments
- Job site evaluations

Immunizations are available on request including, but not limited to:

- Hepatitus B (series of three).
- TDAP.
- Tetanus
- Influenza.

Reporting and Records

- Employee will receive a summary letter via the mail as soon as medical exam results are reviewed. Results will be reviewed within 5 working days of the examination.
- The employee's designated physician can receive a report if desired by the employee.
- If any employee is deemed unfit to perform their assigned duties due to a medical condition in light of the medical exam, their job description and any regulatory requirements for their position, the designated City contact will be notified immediately.
- Employer Representatives will receive a report on all physicals performed at the clinic.
- USAR representatives currently receive via email, the entire patient chart to help them maintain the most current records in the event of deployment.
- Strict confidentiality is our highest priority and will be maintained at all times.
- Company Care currently has the past ten years of the City's employee medical records at our location. We will maintain these medical records at our location until the contract for service ends or is transferred to a new vendor.
- Medical records are maintained for services provided in a manner to ensure confidentiality. Access to or disclosure of records is based upon Company Care receiving an appropriate signed consent or disclosure authorization from the employee or as otherwise permitted by applicable law, including the Nebraska Workers' Compensation law. Reports are provided in hard copy on a timely basis to involved parties in the treatment plan or case management.

We will communicate to the city officials on a timely basis regarding physical examination results. We have a clear understanding of the various physical exams and the reporting necessary.

5.2.3 Part III: Experience

5.2.3.1 Company Care's Medical Director, Dr. David Durand, is a board certified occupational medicine physician, which is a recommendation by the NFPA 1582-22, section D-2.

Company Care's team of providers brings professional expertise in:

- Back safety and overall injury prevention;
- Identifying exposure and injury risks;
- Medical care and treatment to increase the overall health of any employer's workforce;
- Identifying examination needs for individuals performing specific job functions
- Awareness and understanding of the DOT and NFPA 1582 requirements; and
- Past experience in providing these medical examinations.
- Have established a six year healthcare relationship with individual city employees; each year developing a more concise healthcare plan.

The Occupational Health staff at Company Care has been providing services to business and industry since 1990. We are dedicated to providing the highest quality of care for our clients. Our professionalism and personalized service distinguishes us from others in the occupational health field.

- Our nurses are active in the Nebraska and American Association of Occupational Health Nurses.
- We currently have Certified Occupational Health Nurses (C.O.H.N.) on our staff. Criteria for certification includes knowledge of toxicology, expertise in treating chemical exposures, competence in physical assessment, understanding of ergonomics and knowledge of OSHA regulations.
- We have six (6) Certified Breath Alcohol Technicians trained in the use of the Breath Alcohol Intoxilizer, which supports the Federal Department of Transportation regulations regarding breath alcohol testing.

5.2.3.2 We are currently providing services for the following public sector employers:

- CHI Health – St. Elizabeth
- Lincoln Electric System
- City of Lincoln
- University of Nebraska
- Duncan Aviation

Client References

The clients listed below are currently utilizing our services. All references are accurate and current.

City of Lincoln
Will Gross
555 S. 10th Room 302
Lincoln, NE 68508
441-7671
Employees – 1000+
Injury treatment, fit for duty exams, respirator exams and on-site wellness presentations
Service time: 2001-present

City of Lincoln – Firefighters
Chief Mike Despain
1801 Q St.
Lincoln, NE 68508
441-7315
Employees – 200+
DOT physicals, annual physicals, fit for duty exams, drug screens, and immunizations
Service time: 2003-present

CHI Nebraska- Employee Health (Lincoln, Kearney, Nebraska City, Grand Island)
Denise Robertson – Director of Human Resources –CHI Nebraska
12809 W Dodge Rd
Omaha, NE 68154
Denise.robertson@alegent.org
Employees – 10,000+
Post-hire screens, blood borne pathogen exposure, injury treatment, drug screening, on site employee health
Service time: 2004-present

Lincoln Electric System
Jim Rigg
PO Box 80869
Lincoln, NE 68501
473-3219
Employees – 425+
Post offer employment screens, nurse screens, back screens, drug screens, injury treatment, and hazmat physicals
Service time: 1998-present

<u>Duncan Aviation</u>
Leon Holloway
PO Box 81887
Lincoln, NE 68501
479-1545
Employees – 1500+
Post offer, random and DOT drug testing and work comp injury care
Service time: January 2006-present

5.2.3.3 Company Care is able to provide flexible services to City/County departments. Specific medical exam components, as-needed services and fees are listed separately for your convenience in Part IV, 5.2.4.1.

5.2.4 Part IV: Cost Proposal

5.2.4.1 Exam Elements and Fees

Firefighter/Police/Transit/Other Employee Medical Exam may include the following:

DOT Physical.. $45.00
Medical exam may include the following.. $55.00

- In depth medical and occupational history
- Physician/Physician Assistant Exam
- Blood pressure/pulse resting
- Blood pressure/pulse following activity of PFT
- Vital signs
- Height and weight
- Vision/Color testing
- Whisper hearing test if no audiogram indicated
- Urinalysis (UA dip)

EKG.. $45.00
PFT.. $25.00
Respirator Questionnaire Review.. $25.00
Chemistry /Lipid/Thyroid/Hematology Profile................................ $40.00
(or $20.00 per profile)
Audiogram (if fails whisper test).. $15.00
PPD for TB testing.. $20.00

Immunizations available upon request include:

Hepatitis B (series of three)... $192.00
TDAP... $61.00
Tetanus... $38.00
Flu-Quadrivalent(based on 2018 prices).. $25.00

Miscellaneous Reporting:

Aggregate Cholesterol/Glucose Report.......................................No Charge
Satisfaction Survey Summary...No Charge

The prices quoted above, reflects approximately a 20% or more discount from our usual and customary charges.

City of Lincoln/Lancaster County Pricing Addendum

To include: Lancaster Co. Sherriff's Dept., Lancaster Co. Corrections, Lancaster Co. Youth Services

5.2.4.2 Exam Elements and Fees – Addendum(8/5/13)

Lancaster Co. Sherriff/County Corrections/County Youth Services exam may include the following:

Medical exam may include the following.. $55.00

- In depth medical and occupational history
- Physician/Physician Assistant Exam
- Blood pressure/pulse resting
- Vital signs
- Vision - Snellen
- Height and weight
- Whisper hearing test if no audiogram indicated

Vision: Ishihara w/Titmus.. $17.00
U/A Dip.. $11.00
EKG.. $45.00
PFT.. $25.00
Respirator Questionnaire Review.. $25.00
X-Ray PA-1 View... $75.00
X-Ray PA/LA.. .$100.00
Chemistry /Lipid/Thyroid/Hematology Profile................................... $40.00
(or $20.00 per profile)
Audiogram (if fails whisper test)... $15.00
PPD for TB testing... $20.00
Post Hire Therapy Screen(Back/Functional Screen)............................... $60.00
Drug Screen Collection Only.. $22.00

Immunizations available upon request include:

Hepatitis B (series of three)... $192.00
TDAP.. $61.00
Tetanus... $38.00
Flu-Quadrivalent(based on 2018 prices).. $25.00

The prices quoted above, reflects approximately a 20% or more discount from our usual and customary charges.

5.2.4.3 Plan of Compensation

The City of Lincoln will be billed monthly, net 30 days.

5.2.4.4 Evaluation and treatment for work injury, illness or blood borne pathogen exposure will follow the current Work Comp Contract between the City of Lincoln and Company Care.

Additional Medical Records Fee:
An additional cost of $.30/page + postage + tax may be assessed depending on request.

5.2.4.5 Knowledge of NFPA 1582 Medical Requirements

Company Care's staff is well prepared to provide medical exams for all City employees that require regulatory compliance. All medical exams will meet or exceed the stated requirements for OSHA, the DOT and NFPA 1582.

Company Care can provide other services and screenings for City employees. Information about such additional services and screenings are available upon request.

5.2.5 Part V: Proof of Insurance

5.2.5.1 Company Care is covered by Workers' Compensation coverage, Commercial General Liability, Automobile Liability, and Professional Errors and Omissions Liability insurance. In addition, medical malpractice insurance is maintained on Dr. Durand and Penni Jackson through The Physician Network.

Copies of the required insurance documents, including the current endorsement for Company Care's Medical Professional Liability insurance in which the City of Lincoln is listed as an additional insured, are enclosed.

Preferred Professional Insurance Company®
P.O. Box 540658, Omaha, NE 68154-0658
Phone: 800.441.7742 Fax: 402.392.2673

CERTIFICATE OF INSURANCE

The Physician Network
2000 Q St
Ste 500
Lincoln, NE 68503-3610

This certificate is issued as a matter of information only and confers no rights upon the certificate holder. This certificate does not affirmatively or negatively amend, extend or alter the coverage afforded by the policies below. This certificate of insurance does not constitute a contract between the issuing insurer, authorized representative or producer, and the certificate holder.

This is to certify that the policies of insurance listed below have been issued to the insured named below for the policy period indicated. Notwithstanding any requirement, term or condition of any contract or other document with respect to which this certificate may be issued or may pertain, the insurance afforded by the policies described herein is subject to all the terms, exclusions and conditions of such policies. Limits shown may have been reduced by paid claims.

INSURED'S NAME: David Richard Durand, DO

POLICY NAME: The Physician Network

ADDRESS: 2000 Q St
Ste 500
Lincoln, NE 68503-3610

POLICY TYPE: Claims Made - Physician & Surgeon Professional Liability

RATING CLASS: Occupational Medicine

POLICY NUMBER: CHP0043314

POLICY LIMITS: $500,000 Per Incident
$1,000,000 Annual Aggregate

PHYSICIAN POLICY TERM: 7/1/2017 TO 7/1/2018

PHYSICIAN RETRO DATE: 11/1/2004

Coverage is provided for medical incidents under the direction, supervision, or control of: The Physician Network

If this policy is cancelled before the expiration date shown, notice will be delivered in accordance with the policy provisions.

ISSUE DATE: 4/26/2017
MP-MPCERT (9/10)
LDI COI 263077-3 09 10

James McCoy, Assistant Secretary & SVP
Authorized Representative

CERTIFICATE OF INSURANCE

DATE: 4/26/17

PRODUCER:

Preferred Professional Insurance Company®
P. O. Box 540658
Omaha, NE 68154-0658

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER, AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

INSURED:

The Physician Network
2000 Q St
Ste 500
Lincoln, NE 68503-3610

COMPANIES AFFORDING COVERAGE

COMPANY A — PREFERRED PROFESSIONAL INSURANCE COMPANY®

COMPANY B

COVERAGES

THIS IS TO CERTIFY THAT THE POLICIES LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED, NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

CO LTR	TYPE OF INSURANCE	POLICY NUMBER	POLICY EFFECTIVE DATE (MM/DD/YY)	POLICY EXPIRATION DATE (MM/DD/YY)	LIMITS	
	GENERAL LIABILITY ☐ COMM. GENERAL LIABILITY ☐ OCCURRENCE COVERAGE ☐ OWNERS & CONTRACTORS PROTECTION ☐ CLAIMS MADE				GENERAL AGGREGATE	
					PRODUCTS COMP/OP AGG	
					PERSONAL AND ADV INJURY	
					EACH OCCURRENCE	
					FIRE DAMAGE (ANY ONE FIRE)	
					MED EXPENSE (ANY ONE PERSON)	
A	PROFESSIONAL LIABILITY X CLAIMS MADE RETRO DATE 7/1/2002 ☐ OCCURRENCE	CHP0043314	7/1/2017	7/1/2018	$500,000 EACH MEDICAL INCIDENT $1,000,000 ANNUAL AGGREGATE	

All operations necessary and incidental to a health care facility. Hospital has qualified under the Nebraska Hospital-Medical Liability Act.

Evidence of coverage for Penni Jackson, PA-C, while working on behalf of The Physician Network.

CERTIFICATE HOLDER

The Physician Network
Attn: Credentialing Department
2000 Q St
Ste 500
Lincoln, NE 68503-3610

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

James McCoy, Assistant Secretary & SVP

CERTIFICATE OF INSURANCE

DATE: 4/26/17

PRODUCER:

Preferred Professional Insurance Company®
P. O. Box 540658
Omaha, NE 68154-0658

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INSURED:

The Physician Network
2000 Q St
Ste 500
Lincoln, NE 68503-3610

COMPANIES AFFORDING COVERAGE

COMPANY A — PREFERRED PROFESSIONAL INSURANCE COMPANY®

COMPANY B

COVERAGES

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CO LTR	TYPE OF INSURANCE	POLICY NUMBER	POLICY EFFECTIVE DATE (MM/DD/YY)	POLICY EXPIRATION DATE (MM/DD/YY)	LIMITS	
	GENERAL LIABILITY ☐ COMM. GENERAL LIABILITY ☐ OCCURRENCE COVERAGE ☐ OWNERS & CONTRACTORS PROTECTION ☐ CLAIMS MADE				GENERAL AGGREGATE	
					PRODUCTS COMP/OP AGG	
					PERSONAL AND ADV INJURY	
					EACH OCCURRENCE	
					FIRE DAMAGE (ANY ONE FIRE)	
					MED EXPENSE (ANY ONE PERSON)	
A	PROFESSIONAL LIABILITY X CLAIMS MADE RETRO DATE 7/1/2002 ☐ OCCURRENCE	CHP0043314	7/1/2017	7/1/2018	$500,000 EACH MEDICAL INCIDENT $1,000,000 ANNUAL AGGREGATE	

All operations necessary and incidental to a health care facility. Hospital has qualified under the Nebraska Hospital-Medical Liability Act.

Evidence of coverage for Tamora Hemje, APRN, while working on behalf of The Physician Network.

CERTIFICATE HOLDER

The Physician Network
Attn: Credentialing Department
2000 Q St
Ste 500
Lincoln, NE 68503-3610

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

James McCoy, Assistant Secretary & SVP

STATE OF NEBRASKA

DEPARTMENT OF INSURANCE
ɟruce R. Ramge
Director

Pete Ricketts
Governor

May 15, 2017

PHYSICIAN NETWORK/THE
ATTN: LISA WIESE
2000 Q STREET, SUITE 500
LINCOLN NE 68503

RE: Nebraska Hospital-Medical Liability Act
See Attached List

Dear Healthcare Provider:

On May 9, 2017, we received $214,411.00, which represents 26% of the premium which you are being charged by Preferred Professional Insurance Company for $500,000/$1,000,000 limits coverage. Your renewal coverage with the Act is effective from July 1, 2017 to July 1, 2018. It will be necessary to requalify each policy period.

As a reminder, a qualified health care provider shall post and keep posted in a suitable location where all patients may easily see it, a sign of the size and type prescribed by the Director stating they have qualified under the provisions of the Nebraska Hospital-Medical Liability Act 44-2821(4).

If you have any questions regarding this transaction or the Act, you can contact me at (402) 471-2201 or stephanie.hobelman@nebraska.gov.

Sincerely,

Stephanie Hobelman, CISR, CIC
Insurance Analyst
Nebraska Excess Liability Fund

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 06/19/2017

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER
MARSH USA INC.
525 VINE STREET, SUITE 1600
CINCINNATI, OH 45202
Attn: Cincinnati.CertRequest@marsh.com

083084--AL/WC-17-18 2611F

CONTACT NAME:
PHONE (A/C, No, Ext): FAX (A/C, No):
E-MAIL ADDRESS:

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : ACE American Insurance Company	22667
INSURER B : Indemnity Insurance Company of North America	43575
INSURER C : ACE Fire Underwriters Insurance Company	20702
INSURER D :	
INSURER E :	
INSURER F :	

INSURED
2611F20 - CATHOLIC HEALTH INITIATIVES
COMPANY CARE
5000 N. 26TH STREET, SUITE 200
LINCOLN, NE 68521

COVERAGES **CERTIFICATE NUMBER:** CLE-004777051-12 **REVISION NUMBER:** 2

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	COMMERCIAL GENERAL LIABILITY; CLAIMS-MADE / OCCUR						EACH OCCURRENCE	$
							DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
	GEN'L AGGREGATE LIMIT APPLIES PER: POLICY / PRO-JECT / LOC						GENERAL AGGREGATE	$
	OTHER:						PRODUCTS - COMP/OP AGG	$
								$
A	AUTOMOBILE LIABILITY			SCA H0906008A	07/01/2017	07/01/2018	COMBINED SINGLE LIMIT (Ea accident)	$ 2,000,000
	X ANY AUTO						BODILY INJURY (Per person)	$
	ALL OWNED AUTOS / SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	HIRED AUTOS / NON-OWNED AUTOS						PROPERTY DAMAGE (Per accident)	$
							COMP/COLL DED.	$ 1,000/500
	UMBRELLA LIAB / OCCUR						EACH OCCURRENCE	$
	EXCESS LIAB / CLAIMS-MADE						AGGREGATE	$
	DED / RETENTION $							$
B	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N			WLR C64411044 (AOS)	07/01/2017	07/01/2018	X PER STATUTE / OTH-ER	
A	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) N	N / A		WLR C64411032 (AZ, CA, MA)	07/01/2017	07/01/2018	E.L. EACH ACCIDENT	$ 1,000,000
C	If yes, describe under DESCRIPTION OF OPERATIONS below			SCF C64411068 (WI)	07/01/2017	07/01/2018	E.L. DISEASE - EA EMPLOYEE	$ 1,000,000
							E.L. DISEASE - POLICY LIMIT	$ 1,000,000
A	Excess Workers' Compensation			WCU C64411056 (OH, WA)	07/01/2017	07/01/2018	Limit	$1,000,000
							Self-Insured Retention	$1,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)
RE: RFP EMPLOYEE MEDICAL EXAMS.
CITY OF LINCOLN AND LANCASTER COUNTY IS/ARE INCLUDED AS ADDITIONAL INSURED WHERE REQUIRED BY WRITTEN CONTRACT WITH RESPECT TO AUTO LIABILITY.

CERTIFICATE HOLDER
CITY OF LINCOLN
LANCASTER COUNTY
555 SOUTH 10TH STREET
LINCOLN, NE 68508

CANCELLATION
SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE
of Marsh USA Inc.
Manashi Mukherjee *Manashi Mukherjee*

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FIRST INITIATIVES INSURANCE, LTD
Governor's Square, Suite 4-213-4
23 Lime Tree Bay Ave., P.O. Box 10073
Grand Cayman, KY1-1001, Cayman Islands
(345) 943-2645, Fax (345) 943-2646
Email: firstinitiatives@catholichealth.net

THIS IS TO CERTIFY TO

DATE OF CERTIFICATE ISSUANCE:
July 1, 2017
ORIGINAL DATE OF ISSUANCE
August 18, 2011

NAME AND ADDRESS OF CERTIFICATE HOLDER:

THE PHYSICIAN NETWORK
ATTN: RISK MANAGEMENT
2000 Q STREET, SUITE 500
LINCOLN, NE 68503

CERTIFICATE OF SELF-INSURANCE

That the described self-insurance coverages as provided by the indicated policy and issued by the company has been issued to:

Named Insured: THE PHYSICIAN NETWORK

Address: 2000 Q STREET, SUITE 500
LINCOLN, NE 68503

The Policy identified below by a policy number is in force on the date of Certificate issuance. Self-Insurance is afforded only with respect to those coverages for which a specific limit of liability has been entered and is subject to all the terms of the Policy having reference thereto. This Certificate of Self-Insurance neither affirmatively nor negatively amends, extends or alters the coverage afforded under any policy identified herein.

POLICY NUMBER	POLICY PERIOD
FIPR00717	EFF. 07/01/17 EXP. 07/01/18

TYPE OF SELF-INSURANCE DESIGNATED BELOW	COVERAGES	LIMITS OF LIABILITY
COMMERCIAL GENERAL LIABILITY	BODILY INJURY, PROPERTY DAMAGE, PERSONAL INJURY LIABILITY & MISCELLANEOUS PROFESSIONAL LIABILITY	$10,000,000 Each claim
HEALTHCARE PROFESSIONAL LIABILITY	AS DESCRIBED	$10,000,000 Each claim
		$85,000,000 Shared Aggregate

Claims made coverage. Policy retroactive date is: July 1, 2002

SPECIAL CONDITIONS/OTHER COVERAGES **SITE CODE:** 2611F

EVIDENCE OF GENERL LIABILITY COVERAGE

2611F - NE

Cancellation: Should any of the above described policies be cancelled before the expiration date thereof, the issuing company will endeavor to mail 30 days written notice to the above named certificate holder, but failure to mail such notice shall impose no obligation or liability of any kind upon the company.

Peter Jones

Authorized Representative

FIRST INITIATIVES INSURANCE, LTD
Governor's Square, Suite 4-213-4
23 Lime Tree Bay Ave., P.O. Box 10073
Grand Cayman, KY1-1001, Cayman Islands
(345) 943-2645, Fax (345) 943-2646
Email: firstinitiatives@catholichealth.net

THIS IS TO CERTIFY TO

DATE OF CERTIFICATE ISSUANCE:
July 1, 2017
ORIGINAL DATE OF ISSUANCE
January 21, 2016

NAME AND ADDRESS OF CERTIFICATE HOLDER:

CITY OF LINCOLN/AND OR LANCASTER COUNTY AND/OR
CITY OF LINCOLN/LANCASTER COUNTY PUBLIC BUILDING COMMISSION
555 SOUTH 10TH STREET
LINCOLN, NE 68508

CERTIFICATE OF SELF-INSURANCE

That the described self-insurance coverages as provided by the indicated policy and issued by the company has been issued to:

Named Insured: TPN - COMPANY CARE

Address: 5000 NORTH 26TH STREET, SUITE 200
LINCOLN, NE 68521

The Policy identified below by a policy number is in force on the date of Certificate issuance. Self-Insurance is afforded only with respect to those coverages for which a specific limit of liability has been entered and is subject to all the terms of the Policy having reference thereto. This Certificate of Self-Insurance neither affirmatively nor negatively amends, extends or alters the coverage afforded under any policy identified herein.

POLICY NUMBER	POLICY PERIOD
FIPR00717	EFF. 07/01/17 EXP. 07/01/18

TYPE OF SELF-INSURANCE DESIGNATED BELOW	COVERAGES	LIMITS OF LIABILITY
COMMERCIAL GENERAL LIABILITY	BODILY INJURY, PROPERTY DAMAGE, PERSONAL INJURY LIABILITY & MISCELLANEOUS PROFESSIONAL LIABILITY	$10,000,000 Each claim
HEALTHCARE PROFESSIONAL LIABILITY	AS DESCRIBED	$10,000,000 Each claim
		$85,000,000 Shared Aggregate

Claims made coverage. Policy retroactive date is: July 1, 2002

SPECIAL CONDITIONS/OTHER COVERAGES **SITE CODE:** 2611F20

CITY OF LINCOLN AND/OR LANCASTER COUNTY AND/OR CITY OF LINCOLN/LANCASTER COUNTY PUBLIC BUILDING COMMISSION ARE ADDED AS ADDITIONAL INSURED WITH RESPECT TO GENERAL LIABILITY, SUBJECT TO THE TERMS AND CONDITIONS OF THE POLICY, ATIMA, AS REQUIRED PER RFP #: 16-033.

2611F - NE

Cancellation: Should any of the above described policies be cancelled before the expiration date thereof, the issuing company will endeavor to mail 30 days written notice to the above named certificate holder, but failure to mail such notice shall impose no obligation or liability of any kind upon the company.

Authorized Representative

CURRICULUM VITAE

David R. Durand DO, MPH, MBA
Company Care
5000 N 26th St., Suite 200
Lincoln, NE 68521
Phone (402) 475-6656

Year of Birth: 1954

EDUCATION

Undergraduate	University of South Florida Tampa, FL B.S., Medical Technology, 1975 B.A., Microbiology, 1975
Medical	University of Osteopathic Medicine Des Moines, IA D.O., June 1, 1984
Internship	Suncoast Hospital Largo, FL Osteopathic Rotating July 1, 1984 - June 30, 1985
Residencies	Bayfront Medical Center St. Petersburg, FL Family Practice July 1, 1985 - June 30, 1988
	University of Michigan Ann Arbor, MI Occupational Medicine September 1991 - March 1996

EDUCATION Continued

University of Michigan
Master of Public Health (MPH)
1993

Univeristy of Iowa
Master Business Administration (MBA)
2001

CURRENT MEDICAL LICENSURE

Nebraska License #392 Osteopathic Physician and Surgeon

CERTIFICATIONS

American Board of Preventive Medicine (Occupational Medicine), February 1997

American Board of Family Medicine: July 1988; re-certified 1994, 2001, 2008

American Osteopathic Board of Neuromusculoskeletal Medicine and Osteopathic Manipulative Medicine, November 2001; re-certified March 2011

Certified Independent Medical Examiner: re-certified August 2011

Medical Review Officer: 1994, 1999, 2004, 2007, 2012

Certificate of Added Qualifications in Pain Medicine 7/31/13

National Registry Certified Medical Examiners (NRCME) 01/08/14

Certified Professional Supervisor/Audiometric (CPS/A) 5/01/14

MEMBERSHIPS

American College of Occupational and Environmental Medicine (ACOEM)

Central States Occupational Medicine Association- Board of Governors 2001-2003

Linn County (Iowa) Medical Society- Board of Directors 2003-2004

American Osteopathic Association (AOA)

American Academy of Osteopathy (AAO)

MEMBERSHIPS Continued

Lancaster County Medical Society & Nebraska Medical Association

National Association Occupational Health Professionals (NAOHP) Board of Directors 2008-2009

RELEVANT PROFESSIONAL EXPERIENCE

January 2012 - Present	Medical Director Occupational Health CHI Greater Nebraska
November 1, 2004 – 2011	The Physician Network Company Care-Medical Director Lincoln, Nebraska
August 1, 1996 – October 04	Physicians' Clinic of Iowa Cedar Rapids, IA Occupational Medicine Physician
March 1994 - July 1996	Wesley Occupational Health Services Wichita, KS Physician
November and December 1994	General Motors Lansing, MI (Temporary part-time)

SPECIAL INTERESTS

Musculoskeletal Medicine, Population Health, Spanish, Infection Prevention

Rev. 04/13/15

CURRICULUM VITAE
OF

PENNI F. JACKSON P.A.-C

ADDRESS: 12200 Emmawalter Rd.
Lincoln, NE 68517
TELEPHONE: 402-525-6810
EMAIL: pennijackson@hotmail.com

EDUCATION:

2001-2003 University of Nebraska Medical Center – Omaha, NE
Masters of Physician Assistant Studies

1996-2000 University of Nebraska – Lincoln, NE
Bachelor of Science: Exercise Science
University Dean's List

PROFESSIONAL EXPERIENCE:

2009- The Physician Network – Lincoln, NE
Occupational, Emergency and Internal Medicine Physician Assistant
Company Care, Saint Elizabeth Emergency Department and Internal Medicine Services

2011-2012 Aesthetic Surgical Images – Omaha, NE
Physician Assistant
Plastic Surgery

2009-2011 Daniel Samani M.D. P.C. – Lincoln, NE
Orthopedic Physician Assistant
Orthopedic Medicine/Surgery

2003-2009 Nebraska Heart Institute – Lincoln, NE
Cardiovascular Physician Assistant
General Cardiology

LICENSURE:

State Board of Nebraska Medical Examiners Division of Physician Assistant
#1137

CERTIFICATIONS:

2003- NCCPA (National Commission on Certification of Physician Assistants)
2003- ACLS (Advanced Cardiac Life Support)
2003- BLS (Basic Life Support)
2003-2005 PALS (Pediatric Advanced Life Support)

PROFESSIONAL MEMBERSHIPS:

2003-	Nebraska Academy of Physician Assistants (NAPA) - Fellow
2012-	- Judicial Committee Chair
2010-2012	- Board Member at Large
2008-2010	- Secretary
2003-	American Academy of Physician Assistants (AAPA) – Fellow
2001-2003	Loran Schmidt Society (UNMC) – Treasurer
1998-2000	UNL Physician Assistant Club – President

CLINICAL PRACTICE AND ACCOMPLISHMENTS:

Practice – Provide acute, chronic and preventative health care by assessing, diagnosing, coordinating care, educating and documenting pertinent information in collaboration with the physician in order to meet patient care, hospital and national guidelines. Serve as a resource and educator to patient, family members, employers and staff.

Accomplishments:

2009-2011	Nebraska Heart Institute Implemented new night call rotation schedule for NHI Mid-Level providers
2006-2008	Nebraska Heart Institute Coordinator of UNMC & Union College student rotation at NHI
2003	Nebraska Academy of Physician Assistants Annual Conference Lecture – *"The Orthopedic Consequences of Smoking and Smoking Cessation"*

REFERENCES AVAILABLE UPON REQUEST

TAMMI A. HEMJE, APRN, MSN, COHN-S

2777 I Road
Syracuse, NE 68446
Home: 402.269.3328 cthemje@windstream.net Cell: 402.269.4443

SUMMARY OF QUALIFICATIONS

Results-focused **Nurse** Practitioner with extensive occupational health nursing and supervisory experience within the pharmaceutical and food industries. Excellent clinical skills with expertise in Worker's Compensation, Short-Term-Disability, FMLA, OSHA and ADA. Promotes health and wellness programs in achieving a healthy, productive workforce. Adept at functioning seamlessly in a team environment and as an individual contributor and team player

PROFESSIONAL EXPERIENCE

Catholic Health Initiatives, Omaha and Lincoln, NE **2015 - Present**

Nurse Practitioner - Occupational Medicine
Providing employee health services from wellness to urgent care for broad base employer population.

Catholic Health Initiatives, Lincoln, NE **2014-2015**

Occupational Health Nurse/PRN
Employee Health Services including Injury and illness assessment and treatment, Worker's Compensation, OSHA record keeping, ergonomics, respiratory, vaccination, exposure control and light duty programs. Work at the 3 occupational sited St. Elizabeth, Nebraska Heart and St. Mary's Nebraska City.

Kelly Services for Novartis, Lincoln, Ne **2013 - Present**

Occupational Health Nurse/PRN
Planned, coordinated and directed Employee Health Services including Injury and illness assessment and treatment, Worker's Compensation, management of OSHA record keeping, ergonomics, respiratory, vaccination, exposure control and light duty programs.

PFIZER, INC., Lincoln, NE **1992 – 2013**

Occupational Health and Wellness Manager 2000 – 2013
Directed Occupational Health and Wellness for 4 biological manufacturing sites and a staff of 4. Managed a budget of $850K+. Oversaw multiple outside vendors. Case Manager for Worker's Compensation, Short-Term-Disability, FMLA and ADA for the Animal Health Manufacturing facilities.

- Implemented and managed programs, ensuring OSHA medical compliance of health and wellness programs. Performed and managed Medical Surveillance for the Animal Health Manufacturing facilities.
- Administered implementation of Electronic Medical Record systems to multiple sites and maintenance through quality assurance processes.
- Created ambitious health and wellness programs, resulting in excellent attendance, evaluations, and improved health outcomes. Surpassed corporate goals of 85% participation in numerous health and wellness initiatives by maintaining frequent contact with all levels of employees through various methods of communication.
- Experienced in Biological Safety, conducted extensive biological review for safety, exposure control and medical surveillance for biologicals in R&D and manufacturing.

Health and Safety Specialist 1992 – 2000

Managed activities required for promoting and protecting employee health and safety at a facility of over 850 employees, and a budget and staff of 2.

- Initiated and provided medical treatment for emergency and non-emergency incidents. Case managed all Short term disability, FMLA, ADA and Workers Compensation. Implemented the site's Medical

Surveillance Programs, Wellness, Vaccination, FMLA, Random Drug Screening and Workers' Compensation Programs.

- Applied experience with implementation of Electronic Medical Record systems and quality assurance, resulting in accurate, well-documented records.
- Developed programs, assuring a healthy and safe work environment through training and consultation in OSHA standards, injury preventative practices, fitness maintenance and restoration of employee health.
- Contributed experience in ergonomic, respiratory, confined space, lockout / tag out, Personal Protective Equipment (PPE), biological exposures, industrial hygiene, and medical surveillance programs, enabling a safe, clean and productive work environment.

FARMLAND FOODS, INC., Crete, NE **1988 – 1992**

Occupational Health Nurse

Planned, coordinated and directed Employee Health Services including Worker's Compensation, management of OSHA record keeping, ergonomics, and light duty programs. Oversaw Plant Emergency Organization and supervised medical staff including 2 nurses.

EDUCATION

Family Practice Nurse Practitioner Certification, Clarkson College, Omaha, NE

MS, Nursing Administration, Nebraska Wesleyan University, Lincoln, NE

BS, Nursing, Nebraska Wesleyan University, Lincoln, NE

Diploma, Nursing, Registered Nurse, Bryan School of Nursing, Lincoln, NE

CERTIFICATIONS / MEMBERSHIPS

American Nurses Credentialing Center (ANCC) 2015001272

Certified Occupational Health Nurse Specialist (COHN-S)

Certified Occupational Hearing Conservationist (CAOHC) 1992-2014

NIOSH-Approved Spirometry Certification 2000 -2014

Board of Directors, Nebraska Safety Council, October 1998 – December 2006

American Heart Association BLS - current

National Safety Council First Aid Instructor 2000-2013

PROFESSIONAL LICENSE

Nebraska APRN -Nurse Practitioner 111861

Nebraska Registered Nurse, License number 44110

Lisa M. Haas

Professional Experience

Director Of Occupational Medicine July 2011-present
Company Care, Lincoln NE
Responsible for the overall program administration of Company Care, an Occupational Medicine clinic, which is part of The Physician Network. This includes strategic planning, budget, business development and operations.
Led the design and implementation of a standardized CHI Employee Health Clinic and Work Comp Case Management model to include 6 clinics across the state of Nebraska. Responsibilities include strategic planning, budget, policies, procedures and staff development.
Experience with regulatory compliance such JCAHO, CDC, OSHA and other federal, state, and agency laws, regulations and guidelines.
Work with other clinical leaders to develop a continuum of care and best practice standards for our CHI Health Occupational Health and Employee Health services.
Experience with maintaining a collegial and cooperative relationship with other leaders in the organization to work as a team to search out and implement efficiencies and economies.
Experience with interviewing, hiring, training, orienting and terminating staff.

Program Manager May 2004 – July 2011
Company Care, Linocln, NE
Responsible for the overall program administration for Company Care. Duties include negotiating on-site nursing contracts with client companies, supervising clinic staff and occupational health nurses, managing overall budget, and developing strategic plan and direction for the program.

Corporate Health Account Executive July 2002 – May 2004
Company Care, Lincoln, NE
Responsible for sales and marketing to 750 client companies, including giving presentations, developing company protocols, communicating with staff regarding client company preferences, and assisting with operations.

Assistant Director
Knowledge Beginnings, Lincoln, NE August 2000 – July 2002

Corporate/Community Services Coordinator
Capital Region Medical Center, Jefferson City, MO August 1994 – May 2000

CPR Coordinator
Still Regional Medical Center, Jefferson City, MO October 1993 – August 1994

Health Promotion Nurse
Still Regional Medical Center, Jefferson City, MO March 1993 – August 1994

Central Scheduler
St. Francis Home Health, La Crosse, Wisconsin November 1992 - February 1993

Implementation Specialist
St. Francis Hospital, La Cross, Wisconsin April 1992 – February 1993

Health Unit Coordinator
St. Francis Hospital, La Cross, Wisconsin August 1991 – November 1992

First Responder Team Coordinator
Dakota Clinic, Fargo, North Dakota August 1988 – August 1991

LPN and Exercise Technician
Dakota Clinic, Fargo, North Dakota — August 1987 – August 1991

Department Manager and Instructor
Health Industries, Fargo, North Dakota — August 1986 – December 1991

Education

Human Development and Family Services
North Dakota State University, Fargo, ND

LPN Nursing Program
University of North Dakota/Lake Region, Devil's Lake, ND

Health Unit Coordinator – Certified
East Grand Forks AVTI, East Grand Forks, MN

Activities and Memberships

- Ambassador for Lincoln Chamber of Commerce
- LIBA
- Board member and Vice President of the West O Business Association
- Workwell
- American Heart Walk Chairman
- American Heart Association Heart Ball Facility Chairman
- American Heart Association Board Member
- American Cancer Society Relay for Life Committee Member

References available upon request

Joanne Bartels

4800 Huddersfield Ct.
Lincoln, NE 68516
402-430-2589
jbartels@stez.org

OBJECTIVE

To obtain a position that utilizes my diverse management, marketing and educational experience.

EXPERIENCE

August 2006-Current (2017)CHI Health/Company Care, Lincoln, NE

Sales Strategist Management, sales, service and marketing position consisting of prospecting and selling new clients as well as retaining our current clientele in the occupational healthcare industry. Continually creating new marketing concepts to bring clients to our clinic on a regular basis which include marketing and creating relationships/networking with employers, physicians and their staff, third party administrators, case managers and surrounding communities. Also working as a team and communicating with our own staff to improve the way we deliver our healthcare and how we communicate with our clients.

June 2004-August 2006 Saint Elizabeth Regional Medical Center, Lincoln, NE

Audio/Visual Room Scheduling-Educational Services

Support position consisting of managing Meeting/Event scheduling as well as assisting and maintaining all audiovisual equipment/services. Also coordinated services with Information Technology, Environmental Services Staff and Dietary Staff. Also assisted Human Resources with coordination of Tuition Reimbursement Program offered by the hospital and backup as needed. Communicated and worked with all levels of associates as well as outside sources utilizing the hospital to give Saint Elizabeth a professional image and atmosphere for events/meetings.

EDUCATION

Bachelor of Science Degree
Business Administration - Management/Marketing Option
Wayne State College, Wayne, Nebraska

TECHNICAL

Proficient in Microsoft Word, Excel, Power Point, Outlook, Lotus, Microsoft Works, Word Perfect, ACT usage including synchronization, Internet usage/email, STIX, MOX.

Continued Education: Effective Supervisory Management, Six Hats Thinking, Priority Management, Excellent Customer Service, OSHA General industries training, Practical training in Occupational Health Sales and Marketing.

REFERENCES - AVAILABLE UPON REQUEST

Brooke E. J. Boutin

brookeboutin@catholichealth.net

Professional Summary- Dedicated employee with over 19 years of nursing experience, including 10 years of acute and critical care hospital nursing, 4 years of post-hospitalization case management, and 5 years of coordinating an Occupational Health Clinic.

Highlights- Proven record of implementing new processes in the Occupational Health Clinic to improve patient outcomes and increase clinic efficiency * Dedicated worker with demonstrated reliability and responsibility * Broad clinical experiences and knowledge base * Strong analytical skills and problem solving abilities * Solid leadership, coaching, and education skills * Extensive knowledge of occupational health policies and procedures, community health resources, and acute care practices and procedures

Experience-

Company Care, Dec 2017- Present, Occupational Health Supervisor

June 2013- Dec 2017, Clinic Coordinator

Responsibilities include: Assisting Divisional Manager of Occupational Health with personnel management including supervision, hiring, evaluating, training, motivating, and payroll processing. Assist with daily oversight of all business office functions. Provide leadership for practice functions in the areas of operational processes, ensuring all regulatory requirements are met. Responsible in cooperation with the Divisional Manager of Occupational Health for oversight of patient satisfaction. Facilitate the timely resolution of practice and patient concerns in accordance with practice protocol and network policies. Monitor and approve accounts payable. Orient new clinic employees.

Tabitha Healthcare Services, July 2009-June 2013, Care Navigator

Responsibilities included: Primary Liaison to Bryan Health. Point of contact for all patients and Bryan Health employees to provide post hospitalization services through Tabitha Healthcare. Included: Assessment for appropriate level of care, ensuring adequate payer sources were in place and evaluate for criteria of Medicare and Medicaid appropriateness. Navigated patients and families through post hospitalization care and worked with insurance companies to solidify

information and payment. Also a member of the Sales and Marketing team with Tabitha Senior Administration to assist in development of a new Assisted Living Facility.

Bryan Health, 1999-2009, Acute and Critical Care LPN

Responsibilities included: Patient assessments, patient and family education, carrying out of physician orders including treatments and medication administration. Collaborate with RN to ensure plan of care was executed. Member of the Bryan Data Review Team which included review of patient charts to ensure staff and physician safety standards were met and Best Practice committee.

COMPANY CARE POLICIES AND PROCEDURES

Policy:	**Medical Records: Storage and Purging**
Approved by:	________________________
Approved by:	________________________
Effective Date: Revised Date:	November 27, 2002 February 10, 2010

Purpose: To establish a consistent standard for purging and storing medical records at Company Care.

Policy:

1. Medical records will be stored in the medical records area in our core for physicals and urgent care medical treatment for five consecutive years. Drug screen collection records and breath alcohol records (for clients who came for a drug screen and/or breath alcohol only with no other services) will be scanned in to our computers then originals destroyed, and kept for two consecutive years.
2. Medical records will be tabbed by year. On an ongoing basis, the charts or medical records will be purged. Purged charts and records will be stored in the Autumn Ridge basement, filed alphabetically by year. Drug screen and/or breath alcohol records (for clients who came for a drug screen and/or breath alcohol only with no other services) will be filed separately from medical records for physicals, urgent care treatment etc.
3. Retention of records will be as follows:
   a. Positive drug screen and breath alcohol test results will be maintained for (5) years in the Drug Testing Coordinator's office.
   b. Physicals – All physicals such as DOT, pre-employment, fit for duty, etc. – 10 years after employee terminates with the company except Hazmat (OSHA) are 30 years.
   c. Injury evaluation for workers' compensation cases – 10 years
   d. Injury evaluation for non-workers' compensation cases – 10 years
   e. Respirator questionnaires – 30 years after employee terminates with the company (OSHA)
   f. Flu shot consents – 1 years (10 years after the age of 21)
   g. OHSA Blood Exposures-forever

	Extremely Satisfied	Very Satisfied	Satisfied	Very Dissatisfied	Extremely Dissatisfied	N/A
The ease of making an appointment.	171	29	8	0	0	57
The courtesy and friendliness of the person at the front desk.	167	46	8	0	0	9
The length of time between making an appointment and the day of your visit.	119	33	6	1	0	57
The helpfulness and friendliness of your nurse.	180	33	5	1	0	0
How well the nurse listened to your concerns.	163	22	8	0	0	6
Your physician or physician's assistant's skills and abilities.	150	32	21	0	0	2
How well your physician or physician's assistant explained your diagnosis and treatment.	144	38	18	0	0	13
The amount of time your physician or physician's assistant spent with you.	146	42	84	1	0	1
How quickly the physician or nurse returned your phone call.	85	23	4	0	0	108
The way we handled your confidential information.	142	43	23	0	0	10
Ease of finding the clinic.	147	38	26	0	0	24
Your overal satisfaction of the care provided to you.	158	43	14	0	0	0
	Injury Care	Occupational Health Physical	Drug Screen	Other		
Service Received						
What did you like best about our clinic?	location, nurses are pretty cool, doctor explained everthing, friendliness of staff, organized, wonderfull blood draws, nice smiles of staff.					
Was there anything that frustrated you?	The time I had to wait to see the doctor, I'm not at as cool as the nurses, no potion to melt my body fat, frustration you won't pre-populate forms.					
Optional:	great, thorough and friendly, need more office décor					
Name						
Employer						
I'd like to be contacted about my concerns/Phone						
Concern:						

Medical History Questionnaire

Company Care
5000 N 26th St. • Suite 200 • Lincoln, NE 68521 • Phone 402.475.6656

Patient Name: ____________________ Date of Service: ____________ DOB: __________

Age: ____________________ Sex: ☐M ☐F

Employer: ____________________ Job Title: ____________ Phone: __________

		Yes	No	Date
1	A. Birth defects			
	B. Head Injury			
	C. Neck Injury			
2	A. Defective vision			
	B. Color blindness			
	C. Injury to Eye			
	D. Cataract			
	E. Glaucoma			
	F. Blind spots/double vision			
	G. Do you wear glasses/contacts?			
3	A. Ear infection (chronic)			
	B. Mastoid surgery			
	C. Loss of hearing			
	D. Ringing in ears			
	E. Use of hearing aid			
	F. Abnormal hearing test			
4	A. Allergies			
	B. Sinus trouble			
	C. Hay fever			
	D. Frequent colds/sore throats			
	E. Difficulty swallowing			
	F. Frequent hoarseness			
	G. Frequent nosebleeds			
	H. Change in sense of smell			
	I. Change in sense of taste			
5	A. Tuberculosis			
	B. Chest surgery			
	C. Asthma			
	D. Lung collapse			
	E. Breast surgery			
	F. Shortness of Breath			
	G. Chronic cough			
	H. Chest pain/pressure			
	I. Emphysema			
	J. Bronchitis			
	K. Night sweats			
6	A. High blood pressure			
	B. Heart murmur			
	C. Enlarged heart			
	D. Heart disease/failure			
	E. Rheumatic fever			
	F. Heart palpitations			
	G. Heart attack			
	H. Heart medication			
	I. Abnormal EKG			
7	A. Varicose Veins			
	B. Stroke			
	C. Leg Ulcers			
	D. Swelling of ankles			
	E. Leg pain on walking			
	F. Circulation problems			

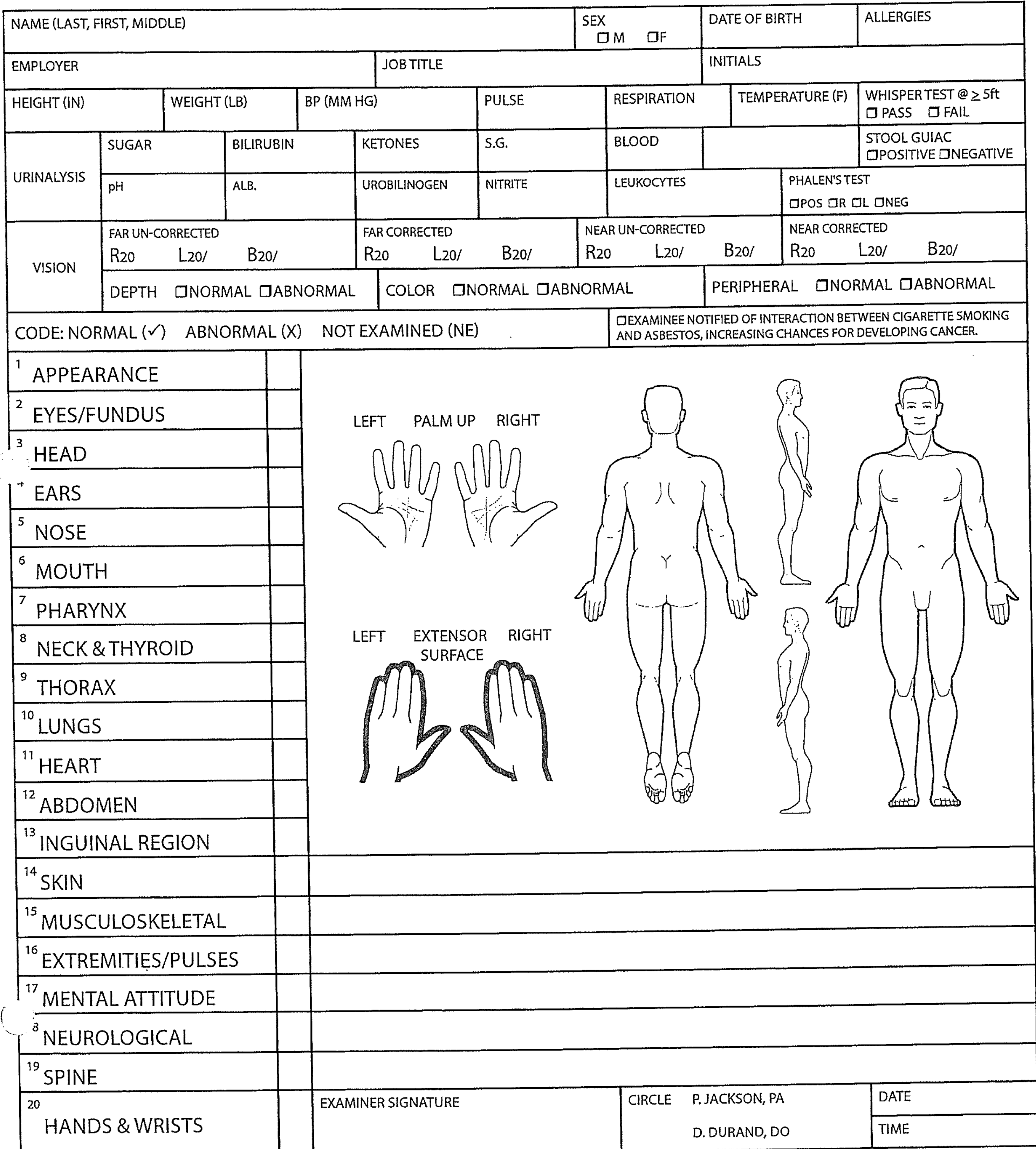
		Yes	No	Date
8	A. Ulcers			
	B. Colitis			
	C. Diarrhea			
	D. Stomach problems			
	E. Vomiting blood			
	F. Bloody stools			
	G. Hepatitis			
	H. Cirrhosis			
	I. Yellow jaundice			
	J. Gallbladder trouble			
	K. Gall stones			
	L. Unrepaired hernia			
	M. Repaired hernia			
	N. Unexplained weight loss			
	O. Frequent vomiting			
	P. Loss/change of appetite			
	Q. Change in bowel habit			
9	A. Epilepsy/seizures			
	B. Fainting spells			
	C. Loss of consciousness			
	D. Dizziness or vertigo			
	E. Frequent exhaustion			
	F. Trouble with nerves			
	G. Frequent worry/depression			
	H. Difficulty with speech			
	I. Loss of coordination			
	J. Severe/migraine headaches			
10	A. Kidney trouble/stones			
	B. Bladder trouble			
	C. Kidney/bladder surgery			
	D. Change in bladder habits			
	E. Blood in urine			
	F. Prostate problems			
11	A. Frequent backaches			
	B. Back surgery			
	C. Disc disease			
	D. Back injury or strain			
	E. Back x-rays			
	F. Chiropractic treatments			
	G. Arthritis			
	H. Rheumatism			
	I. Swollen joints			
	J. Amputations			
	K. Broken bones			
	L. Dislocations			
	M. Painful feet			
	N. Rheumatoid arthritis			
	O. Surgically replaced joint			
	P. Arm problems			
	Q. Wrist problems			
	R. Neck problems			
	S. Shoulder problems			
	T. Knee problems			
	U. Ankle problems			
	V. Carpal tunnel			
	W. Are Right or Left Handed	Left	Right	N/A

The Physician Network

Company Care

5000 N. 26th St. • Suite 200 • Lincoln, NE 68521 • Phone 402.475.6656

PHYSICAL EXAMINATION



❒ HAZMAT ❒ PRE-PLACEMENT ❒ RESPIRATOR ❒ ASBESTOS ❒ OTHER: ____________

NAME (LAST, FIRST, MIDDLE)		SEX ❒ M ❒ F	DATE OF BIRTH	ALLERGIES
EMPLOYER	JOB TITLE		INITIALS	

HEIGHT (IN)	WEIGHT (LB)	BP (MM HG)	PULSE	RESPIRATION	TEMPERATURE (F)	WHISPER TEST @ ≥ 5ft ❒ PASS ❒ FAIL

URINALYSIS	SUGAR	BILIRUBIN	KETONES	S.G.	BLOOD		STOOL GUIAC ❒POSITIVE ❒NEGATIVE
	pH	ALB.	UROBILINOGEN	NITRITE	LEUKOCYTES	PHALEN'S TEST ❒POS ❒R ❒L ❒NEG	

VISION	FAR UN-CORRECTED R20 L20/ B20/	FAR CORRECTED R20 L20/ B20/	NEAR UN-CORRECTED R20 L20/ B20/	NEAR CORRECTED R20 L20/ B20/
	DEPTH ❒NORMAL ❒ABNORMAL	COLOR ❒NORMAL ❒ABNORMAL	PERIPHERAL ❒NORMAL ❒ABNORMAL	

CODE: NORMAL (✓) ABNORMAL (X) NOT EXAMINED (NE)

❒EXAMINEE NOTIFIED OF INTERACTION BETWEEN CIGARETTE SMOKING AND ASBESTOS, INCREASING CHANCES FOR DEVELOPING CANCER.

1 APPEARANCE		
2 EYES/FUNDUS		
3 HEAD		
4 EARS		
5 NOSE		
6 MOUTH		
7 PHARYNX		
8 NECK & THYROID		
9 THORAX		
10 LUNGS		
11 HEART		
12 ABDOMEN		
13 INGUINAL REGION		
14 SKIN		
15 MUSCULOSKELETAL		
16 EXTREMITIES/PULSES		
17 MENTAL ATTITUDE		
18 NEUROLOGICAL		
19 SPINE		
20 HANDS & WRISTS		

EXAMINER SIGNATURE	CIRCLE P. JACKSON, PA / D. DURAND, DO	DATE
		TIME

OCCUPATIONAL HEALTH

TUBERCULOSIS SCREENING RECORD

☐ **New Hire** ☐ **Annual** Location:____________________

Employee Name	DOB	ID #	Department

Tuberculosis (TB) skin testing involves injecting a small amount of a TB protein/diagnostic antigen just under the skin on the inside of the forearm and sometimes slight bruising appears.

Question	Yes	No
1. Have you ever had a positive tuberculosis (TB) skin and/or blood test?	☐ Yes	☐ No
2. Have you ever had TB infection or disease?	☐ Yes	☐ No
3. Have you ever taken isoniazid (INH) or other medications after a positive TB skin or blood test?	☐ Yes	☐ No
4. Have you had a chest x-ray after a positive TB test? If yes, Date ______________ Result ______________	☐ Yes	☐ No
5. Since your last TB update, have you had or are you currently experiencing coughing for > three weeks, loss of appetite, unexplained weight loss, night sweats, bloody sputum or coughing up blood, hoarseness, fever, fatigue, or chest pain?	☐ Yes	☐ No
6. Have you received the BCG vaccine which is an injection given in some countries to prevent TB?	☐ Yes	☐ No
7. Are you immunocompromised or have illness such as cancer, diabetes, HIV, or have history of gastrectomy, organ transplant, or intestinal bypass or body weight ≥ 10% below ideal body weight?	☐ Yes	☐ No
8. Are you taking steroids, cortisone, or other immune lowering medications?	☐ Yes	☐ No
9. Have you had a recent live vaccine, such as MMR (measles/mumps) or Varivax (chickenpox)?	☐ Yes	☐ No
10. Do you have a known allergy to preservatives, natural latex rubber or sensitive to products containing latex ?	☐ Yes	☐ No
11. After reading the provided CDC fact sheet about TB dated __________, I understand the general concepts of TB prevention, transmission, and symptoms.	☐ Yes	☐ No
Born in or traveled in another country, not in the United States? List country(s): ______________	☐ Yes	☐ No
Had contact with person(s) with active TB or foreign-born persons from areas of the world with high prevalence of TB	☐ Yes	☐ No

☐ I authorize CHI Health Occupational Health to provide a TB skin test or blood test today, and **I agree to have the skin test read within the required time of 48-72 hours.** Failure to complete the TB requirements may be a barrier to my job placement.

☐ I **DO NOT** authorize CHI Health Occupational Health to provide a TB skin test or blood test today.

Employee Signature	Date

Date / Time	Forearm Right	Forearm Left	Name of Manufacturer	Manufacturer Lot #	Lot Expiration Date	Initials	Date / Time	Results (mm)	Initials

Name/Signature	Initials	Name/Signature	Initials
Name/Signature	Initials	Name/Signature	Initials
Name/Signature	Initials	Name/Signature	Initials

FOR OFFICE STAFF USE ONLY

General indications for Interferon Gamma Release Assay (IGRA) with QuantiFERON-TB test on new hires or at Providers discretion: (see policy for other indications not listed below).

- A previous BCG vaccine.
- A previous documented positive skin test and no history of treatment.
- An employee on significant dose of steroids (i.e. >15 mg prednisone q. day), tnf-α antagonists, etc., and test reaction is ≥5 mm.
- Previous TB treatment and no history of IGRA.
- Previous documented positive skin test and a negative IGRA blood test and works in designated area; others use above questions.

QuantiFERON-TB Date Drawn: ______________ QuantiFERON-TB Results: ______________

If QuantiFERON-TB positive:

- Order chest x-ray. Date: ______________ Results: ______________
- Complete MD referral form, attach all test results, and refer to primary care physician after OHS medical staff review.

COMPANY CARE
SPIROMETRY PRESCREENING QUESTIONS

Patient Name: ______________________

Date of Birth ______________________

Date: ______________________

YES NO 1. In the last 6 weeks have you had a chest injury or surgery involving the eye, ear chest, abdomen or been hospitalized for a heart attack?
If Yes:
1a. **Do not test at this time. Reschedule spirometry test for 6 weeks.**

YES NO 2. Are you under a physician's care for high blood pressure?
Blood Pressure______________
If Yes:
2a. **If blood pressure exceeds action level, obtain physician clearance before proceeding.**

YES NO 3. Within the last hour have you smoked tobacco?

YES NO 4. Within the last hour have you eaten a full meal?
If Yes:
4a. **If Yes to either smoking or eating, if possible wait one hour before testing, otherwise make notation to overreader and proceed.**

YES NO 5. Have you had a respiratory infection (chest cold, flu, bronchitis or pneumonia) in the last 3 weeks?
If Yes:
5a **Continue with spirometry testing and make notation to overreader.**

YES NO 6. Have you used an inhaled bronchodilator (Primatene Mist, Ventolin) in the last 6 hours?

YES NO 7. Have you had more than 2 cups of caffeinated coffee, tea or cola (total) in the Last 6 hours?
If Yes:
7a **If possible wait one hour before testing, otherwise make notation to overreader and proceed.**

YES NO 8. Are you wearing any tight or restrictive clothing?

YES NO 9. Are you wearing dentures?

Today's Measurements

Height:____________ (inches) Weight: ____________(Pounds, measured by scale)

Certified Spirometry Technician's initials or ID #: ____________

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COMPANY CARE AUDIOGRAM REPORT

Name: ______________________ Age ______ Date of Birth __________ Social Sec. # ___XXX_-_XX__-_______

Reason for Test: ○Pre-Employment ○Baseline ○Periodic ○Retest Employer:__________________

Please Answer Questions Below:

YES	NO	
○	○	Does anyone in your family have a hearing loss? If yes, who?______________________
○	○	Do you now or have you ever had hearing trouble?
○	○	Do you now or have you ever worn or been advised to wear hearing aids?
○	○	Have you ever had your hearing tested? If yes, when and where?______________________
○	○	Have you ever had any ear infection? If yes, which ear?__________
○	○	Have you ever been exposed to gunfire?
○	○	Do you hunt using firearms?
○	○	Have you ever been in the military?
○	○	Do you ride a motorcycle?
○	○	Any other noisy habits? If yes, explain______________________
○	○	Have you ever had surgery on either ear? If yes, which ear?______________
○	○	Have you ever worked at a noisy job? Where? ______________
○	○	Do you have a second job?
○	○	Have you ever had drainage from your ears? If yes, which ear?______________
○	○	Are you taking or have you taken drugs, antibiotics or medications regularly?
○	○	Have you ever had dizziness? If yes, explain:______________________
○	○	Have you ever had noises in your ears? If yes, explain:______________________
○	○	Have you ever had measles, mumps or scarlet fever? If yes, when______________________
○	○	Do you currently have a cold?
○	○	Have you been exposed to loud noises in the past 14 hours? If yes, was hearing protection worn? __________
○	○	Do you wear hearing protection at your job? __________

To the best of my knowledge, the above information is true and complete. Date: __________ Individuals Signature:________________

Clinical Staff to Complete

Tester: ______________________ Audiometer: MAICO MA 800 Series II Calibration Date: 08/28/2013

	LEFT EAR 500	1K	2K	3K	4K	6K	8K	RIGHT EAR 500	1K	2K	3K	4K	6K	8K
Base	___	___	___	___	___	___	___	___	___	___	___	___	___	___
Test 1	___	___	___	___	___	___	___	___	___	___	___	___	___	___
Test 2	___	___	___	___	___	___	___	___	___	___	___	___	___	___

Otoscopic Screening:
Right Ear ○Appears Normal ○Blockage of wax or foreign body that prevents view of the eardrum ○Other:______________
Left Ear ○Appears Normal ○Blockage of wax or foreign body that prevents view of the eardrum ○Other:______________

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Revised 09/05/13

Company Care
(402) 475-6656

OSHA Respirator Medical Evaluation Questionnaire (Mandatory)
Appendix C to Sec. 1910.134

(To the employer: Answers to questions in Section 1, and to question 9 in Section 2 of Part A, do not require a medical examination.)

To the employee:
Can you read (circle one): Yes/No

Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, your employer or supervisor must not look at or review your answers, and your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it.

Part A. Section 1. (Mandatory) The following information must be provided by every employee who has been selected to use any type of respirator (please print).

1. Today's date:________________________
2. Your name (Please Print):____
3. Your age (to nearest year):_______________________Date of birth:___/___/___.
4. Sex (circle one): Male/Female
5. Your height: _________ ft. _________ in.
6. Your weight: ___________ lbs.
7. Your job title:____
8. A phone number where you can be reached by the health care professional who reviews this questionnaire (include the Area Code): __________________ 9. The best time to phone you at this number: ______________
10. Has your employer told you how to contact the health care professional who will review this questionnaire (circle one): Yes/No
11. Check the type of respirator you will use (you can check more than one category):
a. _____ N, R, or P disposable respirator (filter-mask, non- cartridge type only).
b. _____ Other type (for example, half- or full-facepiece type, powered-air purifying, supplied-air, selfcontained breathing apparatus).
12. Have you worn a respirator (circle one): Yes/No
If "yes," what type(s):____
____

Part A. Section 2. (Mandatory) Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator (please circle "yes" or "no").

1. Do you *currently* smoke tobacco, or have you

smoked tobacco in the last month: Yes/No
Have you ever smoked tobacco? Yes/No
If yes, how many packs/day?____________
If yes, how may years have you smoked?__________
If yes, and have quit smoking, how many years ago did you quit?______________

Name(Please Print):__________________ **Date of Birth:**________ **Company**__________

2. Have you *ever had* any of the following conditions?
   a. Seizures (fits): Yes/No
      If yes, when was your last seizure?______________
   b. Diabetes (sugar disease): Yes/No
      If yes, do you take insulin? Yes/No
      If you are diabetic, have you fainted or passed out in the last year? Yes/No
   c. Allergic reactions that interfere with your breathing: Yes/No
      If yes, did you go to the emergency room? Yes/No
   d. Claustrophobia (fear of closed-in places): Yes/No If yes, does claustrophobia interfere with your job? Yes/No If yes, how much would a respirator bother your claustrophobia?
      Circle: not at all, a little bit, medium, a lot, not sure
   e. Trouble smelling odors: Yes/No

3. Have you *ever had* any of the following pulmonary or lung problems?
   a. Asbestosis: Yes/No
   b. Asthma: Yes/No
      If yes, do you take medicine for asthma? Yes/No
      If yes, have you ever been hospitalized for asthma? Yes/No
      Have you ever gone to an emergency room for asthma? Yes/No c. Chronic bronchitis: Yes/No
   d. Emphysema: Yes/No
   e. Pneumonia: Yes/No
      If yes, how many times have you had pneumonia?________
      If yes, when was the last time you had pneumonia?________
   f. Tuberculosis: Yes/No
   g. Silicosis: Yes/No
   h. Pneumothorax (collapsed lung): Yes/No
      If yes, how many times?______________
      If yes, when was the last time?__________
   i. Lung cancer: Yes/No
   j. Broken ribs: Yes/No
      If yes, how many ribs total have ever been broken?__________
      If yes, when was the last rib broken?______________
   k. Any chest injuries or chest surgeries: Yes/No
   l. Any other lung problem that you've been told about: Yes/No

4. Do you *currently* have any of the following symptoms of pulmonary or lung illness?
   a. Shortness of breath: Yes/No
   b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline: Yes/No

If yes, is your shortness of breath worse than others' doing the same activity? Yes/No

c. Shortness of breath when walking with other people at an ordinary pace on level ground: Yes/No

d. Have to stop for breath when walking at your own pace on level ground: Yes/No

e. Shortness of breath when washing or dressing yourself: Yes/No

f. Shortness of breath that interferes with your job: Yes/No

g. Coughing that produces phlegm (thick sputum): Yes/No

h. Coughing that wakes you early in the morning: Yes/No

Name(Please Print):____________________ Date of Birth:________ Company______________

i. Coughing that occurs mostly when you are lying down: Yes/No

j. Coughing up blood in the last month: Yes/No

k. Wheezing: Yes/No

l. Wheezing that interferes with your job: Yes/No

m. Chest pain when you breathe deeply: Yes/No

n. Any other symptoms that you think may be related to lung problems: Yes/No

5. Have you *ever had* any of the following cardiovascular or heart problems?

   a. Heart attack: Yes/No

   If yes, how many heart attacks?__________

   If yes, when was your last heart attack?____________

   b. Stroke: Yes/No

   c. Angina: Yes/No

   d. Heart failure: Yes/No

   e. Swelling in your legs or feet (not caused by walking): Yes/No

   If yes, when was the last time?________________

   f. Heart arrhythmia (heart beating irregularly): Yes/No

   g. High blood pressure: Yes/No

   h. Any other heart problem that you've been told about: Yes/No

6. Have you *ever had* any of the following cardiovascular or heart symptoms?

   a. Frequent pain or tightness in your chest: Yes/No

   b. Pain or tightness in your chest during physical activity: Yes/No

   c. Pain or tightness in your chest that interferes with your job: Yes/No

   d. In the past two years, have you noticed your heart skipping or missing a beat: Yes/No

   e. Heartburn or indigestion that is not related to eating: Yes/ No

   f. Any other symptoms that you think may be related to heart or circulation problems: Yes/No

7. Do you *currently* take medication for any of the following problems?

   a. Breathing or lung problems: Yes/No

   b. Heart trouble: Yes/No

   c. Blood pressure: Yes/No

   d. Seizures (fits): Yes/No

8. If you've used a respirator, have you *ever had* any of the following problems? (If you've never used a respirator, check the following space and go to question 9:) _______

a. Eye irritation: Yes/No
b. Skin allergies or rashes: Yes/No
c. Anxiety: Yes/No
d. General weakness or fatigue: Yes/No
e. Any other problem that interferes with your use of a respirator (chest pain, shortness of breath, weakness, dizziness, other):______________________ Yes/No

9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire: Yes/No

Questions 10 to 15 below must be answered by every employee who has been selected to use either a fullfacepiece respirator or a self-contained breathing apparatus (SCBA). For employees who have been selected to use other types of respirators, answering these questions is voluntary.

10. Have you *ever lost* vision in either eye (temporarily or permanently): Yes/No

Name(Please Print):__________________ Date of Birth:________ Company_____________

11. Do you *currently* have any of the following vision problems?
a. Wear contact lenses: Yes/No
b. Wear glasses: Yes/No
c. Color blind: Yes/No
d. Any other eye or vision problem: Yes/No

12. Have you *ever had* an injury to your ears, including a broken ear drum: Yes/No

13. Do you *currently* have any of the following hearing problems?
a. Difficulty hearing: Yes/No
b. Wear a hearing aid: Yes/No
c. Any other hearing or ear problem: Yes/No

14. Have you *ever had* a back injury: Yes/No

15. Do you *currently* have any of the following musculoskeletal problems?
a. Weakness in any of your arms, hands, legs, or feet: Yes/No
b. Back pain: Yes/No
c. Difficulty fully moving your arms and legs: Yes/No
d. Pain or stiffness when you lean forward or backward at the waist: Yes/No
e. Difficulty fully moving your head up or down: Yes/No
f. Difficulty fully moving your head side to side: Yes/No
g. Difficulty bending at your knees: Yes/No
h. Difficulty squatting to the ground: Yes/No
i. Climbing a flight of stairs or a ladder carrying more than 25 lbs.: Yes/No
j. Any other muscle or skeletal problem that interferes with using a respirator: Yes/No

Part B Any of the following questions, and other questions not listed, may be added to the questionnaire at the discretion of the health care professional who will review the questionnaire.

1. In your present job, are you working at high altitudes (over 5,000 feet) or in a place that has lower than normal amounts of oxygen: Yes/No

If "yes," do you have feelings of dizziness, shortness of breath, pounding in your chest, or other symptoms when you're working under these conditions: Yes/No

2. At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (e.g., gases, fumes, or dust), or have you come into skin contact with hazardous chemicals: Yes/No

If "yes," name the chemicals if you know them:____________________

____

____

3. Have you ever worked with any of the materials, or under any of the conditions, listed below:

a. Asbestos: Yes/No
b. Silica (*e.g.*, in sandblasting): Yes/No
c. Tungsten/cobalt (e.g., grinding or welding this material): Yes/No
d. Beryllium: Yes/No
e. Aluminum: Yes/No
f. Coal (for example, mining): Yes/No
g. Iron: Yes/No
h. Tin: Yes/No
i. Dusty environments: Yes/No
j. Any other hazardous exposures: Yes/No

If "yes," describe these exposures:________________________

4. List any second jobs or side businesses you have:

____

Name(Please Print):______________ **Date of Birth:**______ **Company**____________

5. List your previous occupations:____________________________

____

6. List your current and previous hobbies:________________________

____

7. Have you been in the military services? Yes/No

If "yes," were you exposed to biological or chemical agents (either in training or combat): Yes/No

8. Have you ever worked on a HAZMAT team? Yes/No

9. Other than medications for breathing and lung problems, heart trouble, blood pressure, and seizures mentioned earlier in this questionnaire, are you taking any other medications for any reason (including over-the-counter medications): Yes/No

If "yes," name the medications if you know them:____________________

10. Will you be using any of the following items with your respirator(s)?

a. HEPA Filters: Yes/No
b. Canisters (for example, gas masks): Yes/No
c. Cartridges: Yes/No

11. How often are you expected to use the respirator(s) (circle "yes" or "no" for all answers that apply to you)?:

a. Escape only (no rescue): Yes/No
b. Emergency rescue only: Yes/No

c. Less than 5 hours *per week:* Yes/No
d. Less than 2 hours *per day:* Yes/No
e. 2 to 4 hours per day: Yes/No
f. Over 4 hours per day: Yes/No

12. During the period you are using the respirator(s), is your work effort:
a. *Light* (less than 200 kcal per hour): Yes/No
If "yes," how long does this period last during the average shift:____________hrs.____________mins.
Examples of a light work effort are *sitting* while writing, typing, drafting, or performing light assembly work; or *standing* while operating a drill press (1-3 lbs.) or controlling machines. b. *Moderate* (200 to 350 kcal per hour): Yes/No
If "yes," how long does this period last during the average shift:____________hrs.____________mins.
Examples of moderate work effort are *sitting* while nailing or filing; *driving* a truck or bus in urban traffic; *standing* while drilling, nailing, performing assembly work, or transferring a moderate load (about 35 lbs.) at trunk level; *walking* on a level surface about 2 mph or down a 5-degree grade about 3 mph; or *pushing* a wheelbarrow with a heavy load (about 100 lbs.) on a level surface. c. *Heavy* (above 350 kcal per hour): Yes/No
If "yes," how long does this period last during the average shift:____________hrs.____________mins.

Examples of heavy work are *lifting* a heavy load (about 50 lbs.) from the floor to your waist or shoulder;
working on a loading dock; *shoveling; standing* while bricklaying or chipping castings; *walking* up an 8degree grade about 2 mph; climbing stairs with a heavy load (about 50 lbs.).

13. Will you be wearing protective clothing and/or equipment (other than the respirator) when you're using your respirator: Yes/No
If "yes," describe this protective clothing and/or equipment:________________________

____

14. Will you be working under hot conditions (temperature exceeding 77 deg. F): Yes/No
15. Will you be working under humid conditions: Yes/No
16. Describe the work you'll be doing while you're using your respirator(s):

____

____

Name(Please Print):____________________ **Date of Birth:**________ **Company**________________

17. Describe any special or hazardous conditions you might encounter when you're using your respirator(s) (for example, confined spaces, life-threatening gases):

____

____

18. Provide the following information, if you know it, for each toxic substance that you'll be exposed to when you're using your respirator(s):
Name of the first toxic substance:____________________________
Estimated maximum exposure level per shift:____________________________
Duration of exposure per shift____________________________
Name of the second toxic substance:____________________________
Estimated maximum exposure level per shift:____________________________
Duration of exposure per shift:____________________________
Name of the third toxic substance:____________________________ Estimated maximum exposure level per shift:____________________________

Duration of exposure per shift:____

The name of any other toxic substances that you'll be exposed to while using your respirator:

____

____

____

19. Describe any special responsibilities you'll have while using your respirator(s) that may affect the safety and well-being of others (for example, rescue, security):

____ [63 FR 1152, Jan. 8, 1998; 63 FR 20098, April 23, 1998]

The Physician Network
Company Care
5000 N. 26th St.
Suite 200
Lincoln, NE 68521
Phone 402.475.6656

Examinee Test Report
Occupational Medicine Evaluation

Date: ______________________

To: ______________________

Birthday: ______________________

The results of your tests at Company Care have been received and are

☐ Normal

☐ Abnormal *(list abnormal tests):* ______________________

We recommend prompt follow-up with your personal physician for any abnormalities, and for an explanation of these results. If you do not have a physician and would like one, please contact us at the above location for assistance in locating one. Not all abnormal tests may be significant. Likewise, normal test results do NOT guarantee good health. The purpose of your evaluation at Company Care is handling your work health issues and is NOT a substitute for ongoing care with *your* personal physician. Please see your physician regularly. **Copies of your test reports are available** at the above address, with proper authorization. Thank you.

COMMENTS

Signature	☐ P. Jackson, PA-C ☐ D. Durand, DO	Sent to examinee? ☐ Yes ☐ No Date sent: ___/___/___ Initials: _____

The Physician Network
Company Care
5000 N. 26th St.
Suite 200
Lincoln, NE 68521
Phone 402.475.6656

EMPLOYER REPORT
OCCUPATIONAL MEDICINE EVALUATION

Examinee:	Date:
Date of Birth:	Employer:
Address:	
Telephone:	Job Tile:

Type of Evaluation: ❐ Pre-placement ❐ Fit for Duty ❐ HazMat ❐ Asbestos ❐ Other________________

Based on our evaluation of this examinee on ________________________ (date):

❐ No medical contraindication / restriction to performing this job as described was found.

❐ No medical contraindication to preforming the indicated job but the following accommodations are recommended:

____

____

❐ Based on the probability of substantial harm, this examinee could pose a DIRECT THREAT to self or others. NOT recommended for this position.

❐ Medical hold: waiting for additional information.

❐ Further testing is required to fully evaluate ability of risk

❐ Amended ____

Date: ______________

COMMENTS

Signature	Circle P. JACKSON, PA-C D. DURAND, DO	DATE FAXED____/____/____TIME:______ INITIALS: DATE MAILED____/____/____ INITIALS: DATE E-MAILED____/____/____ INITIALS:

NEBRASKA
Good Life. Great Service.
DEPARTMENT OF REVENUE

Nebraska Resale or Exempt Sale Certificate for Sales Tax Exemption

FORM 13

Name and Mailing Address of Purchaser			Name and Mailing Address of Seller		
Name: City of Lincoln			Name: Lincoln Physician Network LLC dba Company Care		
Legal Name					
Street or Other Mailing Address: 555 S. 10th St.			Street or Other Mailing Address: 5000 N 26th Street, Suite 200		
City: Lincoln	State: NE	Zip Code: 68508	City: Lincoln	State: NE	Zip Code: 68521

Check Type of Certificate

☐ Single Purchase If single purchase is checked, enter the related invoice or purchase order number ____________.

☑ Blanket If blanket is checked, this certificate is valid until revoked in writing by the purchaser.

I hereby certify that the purchase, lease, or rental by the above purchaser is exempt from the Nebraska sales tax for the following reason:

Check One ☐ Purchase for Resale (Complete Section A.) ☑ Exempt Purchase (Complete Section B.) ☐ Contractor (Complete Section C.)

Section A—Nebraska Resale Certificate

I hereby certify that the purchase, lease, or rental of ____________ (Description of Property or Service Purchased) from the seller listed above is exempt from the Nebraska sales tax as a purchase for resale, rental, or lease in the normal course of our business. The property or service will be resold either in the form or condition in which it was purchased, or as an ingredient or component part of other property or service to be resold.

I further certify that we are engaged in business as a: ☐ Wholesaler ☐ Retailer ☐ Manufacturer ☐ Lessor

Description of Product Sold, Leased, or Rented

of ____________

My Nebraska Sales Tax ID Number is 01-____________.

If none, state the reason ____________,

or Foreign State Sales Tax Number____________ State ____________.

Section B—Nebraska Exempt Sale Certificate

The basis for this exemption is exemption category 1 (See the list of Exemption Categories and corresponding numbers on reverse side).

If exemption category 2 or 5 is claimed, enter the following information:

Description of Property or Service Purchased ____________ Intended Use of Property or Service Purchased ____________

If exemption category 3 or 4 is claimed, enter your Nebraska Certificate of Exemption State ID number. 05-____________
Do not enter your Federal Employer ID Number.

If exemption category 6 is claimed, the seller must enter the following information and sign this form below:

Description of Items Sold	Date of Seller's Original Purchase	Was tax paid when purchased by seller?	Was item depreciable?
		☐ Yes ☐ No	☐ Yes ☐ No

Section C—For Contractors Only

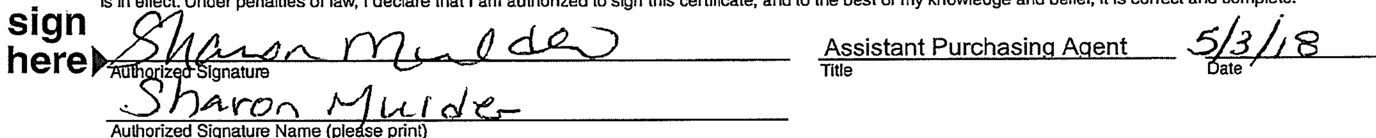
1. Purchase of building materials or fixtures.

☐ As an Option 1 or Option 3 contractor, I hereby certify that the purchase of building materials and fixtures from the seller listed above are exempt from Nebraska sales tax. My Nebraska Sales or Use Tax ID Number is: ____________.

2. Purchases made by an Option 2 contractor under a Purchasing Agent Appointment on behalf of ____________ (exempt entity) ____________.

☐ As an Option 2 contractor, I hereby certify that the purchase of building materials and fixtures from the seller listed above is exempt from Nebraska sales tax pursuant to the **attached** Purchasing Agent Appointment and Delegation of Authority for Sales and Use Tax, Form 17.

Any purchaser, agent, or other person who completes this certificate for any purchase which is not for resale, lease, or rental in the regular course of the purchaser's business, or is not otherwise exempted from sales and use taxes is subject to a penalty of $100 or ten times the tax, whichever amount is larger, for each instance of presentation and misuse. With regard to a blanket certificate, this penalty applies to each purchase made during the period the blanket certificate is in effect. Under penalties of law, I declare that I am authorized to sign this certificate, and to the best of my knowledge and belief, it is correct and complete.



sign here Authorized Signature   Assistant Purchasing Agent (Title)   5/3/18 (Date)

Sharon Mulder
Authorized Signature Name (please print)

Do not send this certificate to the Nebraska Department of Revenue. Keep it as part of your records.
Sellers cannot accept incomplete certificates.

The Department is committed to the fair administration of the Nebraska tax laws. It is unlawful to claim an exemption for purchases of property or services that are subject to tax. Sellers are encouraged to notify the Department of any unlawful use of this form.

revenue.nebraska.gov, 800-742-7474 (NE and IA), 402-471-5729

Instructions

Who May Issue a Resale Certificate. Purchasers are to give the seller a properly completed Form 13, Section A, when making purchases of property or taxable services that will subsequently be resold in the purchaser's normal course of business. The property or services must be resold in the same form or condition as when purchased, or as an ingredient or component part of other property that will be resold.

Who May Issue an Exempt Sale Certificate. Form 13, Section B, may be completed and issued by governmental units or organizations that are exempt from paying Nebraska sales and use taxes. See this list in the Nebraska Sales Tax Exemptions Chart. Most nonprofit organizations are **not** exempt from paying sales and use tax. Enter the appropriate number from "Exemption Categories" (listed below) that properly reflects the basis for your exemption.

For additional information about proper issuance and use of this certificate, please review Reg-1-013, Sale for Resale – Resale Certificate, and Reg-1-014, Exempt Sale Certificate.

Contractors. Contractors complete Form 13, Section C, part 1 or part 2 based on the option elected on the Contractor Registration Database.

To make tax-exempt purchases of building materials and fixtures, Option 1 or Option 3 contractors must complete Form 13, Section C, Part 1. To make tax-exempt purchases of building materials and fixtures pursuant to a construction project for an exempt governmental unit or an exempt nonprofit organization, Option 2 contractors must complete Form 13, Section C, Part 2. The contractor must also attach a copy of a properly completed Purchasing Agent Appointment and Delegation of Authority for Sales and Use Tax, Form 17, to the Form 13, and both documents must be given to the supplier when purchasing building materials. See the contractor information guides and Reg-1-017, Contractors, for additional information. Also, see the Important Note under "Exemption Categories" number 3.

When and Where to Issue. The Form 13 must be given to the seller at the time of the purchase to document why sales tax does not apply to the purchase. The Form 13 must be kept with the seller's records for audit purposes.

Sales Tax Number. A purchaser who is engaged in business as a wholesaler or manufacturer is not required to provide an ID number when completing Section A. Out-of-state purchasers may provide their home state sales tax number. Section B does not require a Nebraska ID number when exemption category 1, 2, or 5 is indicated.

Fully Completed Resale or Exempt Sale Certificate. A fully completed resale or exempt sale certificate is proof for the retailer that the sale was for resale or is exempt. For a resale certificate to be fully completed, it must include: (1) identification of the purchaser and seller, type of business engaged in by the purchaser; (2) sales tax permit number; (3) signature of an authorized person; and (4) the date of issuance.

For an exempt sale certificate to be fully completed, it must include: (1) identification of purchaser and seller; (2) a statement that the certificate is for a single purchase or is a blanket certificate covering future sales; (3) a statement of the basis for exemption, including the type of activity engaged in by the purchaser; (4) signature of an authorized person; and (5) the date of issuance.

Penalties. Any purchaser who gives a Form 13 to a seller for any purchase which is other than for resale, lease, or rental in the **normal** course of the purchaser's business, or is not otherwise exempted from sales and use tax under the Nebraska Revenue Act, is subject to a penalty of $100 or ten times the tax, whichever is greater, for each instance of presentation and misuse. In addition, any purchaser, or their agent, who fraudulently signs a Form 13 may be found guilty of a Class IV misdemeanor.

Exemption Categories

(Insert appropriate number from the list below in Section B)

1. Governmental units, identified in Reg-1-072, United States Government and Federal Corporations; and Reg-1-093, Governmental Units. Governmental units are not assigned exemption numbers.

   Sales to the U.S. government, its agencies, instrumentalities, and corporations wholly owned by the U.S. government are exempt from sales tax. However, sales to institutions chartered or created under federal authority, but which are not directly operated and controlled by the U.S. government for the benefit of the public, generally are taxable.

   Purchases by governmental units that are **not** exempt from Nebraska sales and use taxes include, but are not limited to: governmental units of other states; sanitary and improvement districts; rural water districts; railroad transportation safety districts; and county historical societies.

2. Purchases when the intended use renders it exempt. See Nebraska Sales Tax Exemption Chart.

3. Purchases made by organizations that have been issued a Nebraska Exempt Organization Certificate of Exemption (Certificate of Exemption). Reg-1-090, Nonprofit Organizations; Reg-1-091, Religious Organizations; and Reg-1-092, Educational Institutions, identify these organizations. These organizations are issued a Certificate of Exemption with a state ID number which must be entered in Section B of Form 13.

   Important Note: Nonprofit educational institutions must be accredited regionally or nationally and have their primary campus in Nebraska to be exempt from sales and use tax. Also nonprofit organizations providing any of the types of health care or services that qualify to be exempt must be licensed or certified by the Nebraska Department of Health and Human Services (DHHS) to be exempt from sales and use taxes. There is no sales and use tax exemption prior to these entities being accredited, licensed, or certified. They CANNOT issue either a Resale or Exempt Sale Certificate, Form 13, or a Purchasing Agent Appointment, Form 17, to any retailer or contractor relating to purchases of building materials for construction or repair projects performed prior to being accredited, licensed, or certified. After an entity becomes accredited, licensed, or certified upon completion of the construction project, it may submit a Form 4.

   Nonprofit **health care organizations** that hold a Certificate of Exemption are exempt for purchases for use at their facility, or portion of the facility, covered by the license issued under the Nebraska Health Care Facility Licensure Act. Only specific types of health care facilities and activities are exempt. Purchases of items for use at facilities that are not covered under the license, or for any other activities that are not specifically exempt, are taxable. The exemption is not for the entire organization that offers different levels of health care or other activities, but is limited to the specific type of health care that is exempt. Purchases for non-exempt types of health care are taxable.

4. Purchases of motor vehicles, trailers, semitrailers watercraft, and aircraft used predominately as common or contract carrier vehicles; accessories that physically become part of the common or contract carrier vehicle; and repair and replacement parts for these vehicles. The exemption ID number must be entered in Section B of the Form 13. An individual or business that has been issued a common or contract carrier certificate of exemption may only use it to purchase those items described above prior to the expiration date on the certificate. The certificate of exemption expires every 5 years. (See Nebraska Common or Contract Carrier Information Guide).

5. Purchases of manufacturing machinery and equipment made by a person engaged in the business of manufacturing, including repair and replacement parts or accessories, for use in manufacturing. (See Reg-1-107, Manufacturing Machinery and Equipment Exemption).

6. Occasional sales of used business or farm machinery or equipment productively used by the seller as a depreciable capital asset for more than one year in his or her business. The seller must have previously paid tax on the item being sold. The seller must complete, sign, and give the Exempt Sale Certificate to the purchaser. (See Reg-1-022, Occasional Sales). The Form 13 must be kept with the purchaser's records for audit purposes.

NEBRASKA
Good Life. Great Service.
DEPARTMENT OF REVENUE

Nebraska Resale or Exempt Sale Certificate
for Sales Tax Exemption

FORM **13**

Name and Mailing Address of Purchaser			Name and Mailing Address of Seller		
Name Lancaster County			Name Lincoln Physician Network LLC dba Company Care		
Legal Name					
Street or Other Mailing Address 555 S. 10th St.			Street or Other Mailing Address 5000 N 26th Street, Suite 200		
City Lincoln	State NE	Zip Code 68508	City Lincoln	State NE	Zip Code 68521

Check Type of Certificate

☐ Single Purchase — If single purchase is checked, enter the related invoice or purchase order number ________________.

☑ Blanket — If blanket is checked, this certificate is valid until revoked in writing by the purchaser.

I hereby certify that the purchase, lease, or rental by the above purchaser is exempt from the Nebraska sales tax for the following reason:

Check One ☐ Purchase for Resale (Complete Section A.) ☑ Exempt Purchase (Complete Section B.) ☐ Contractor (Complete Section C.)

Section A—Nebraska Resale Certificate

I hereby certify that the purchase, lease, or rental of ________________ (Description of Property or Service Purchased) from the seller listed above is exempt from the Nebraska sales tax as a purchase for resale, rental, or lease in the normal course of our business. The property or service will be resold either in the form or condition in which it was purchased, or as an ingredient or component part of other property or service to be resold.

I further certify that we are engaged in business as a: ☐ Wholesaler ☐ Retailer ☐ Manufacturer ☐ Lessor

of ________________ (Description of Product Sold, Leased, or Rented)

My Nebraska Sales Tax ID Number is 01-________________.

If none, state the reason ________________,

or Foreign State Sales Tax Number ________________ State ________________.

Section B—Nebraska Exempt Sale Certificate

The basis for this exemption is exemption category 1 (See the list of Exemption Categories and corresponding numbers on reverse side).

If exemption category 2 or 5 is claimed, enter the following information:

Description of Property or Service Purchased ________________ Intended Use of Property or Service Purchased ________________

If exemption category 3 or 4 is claimed, enter your Nebraska Certificate of Exemption State ID number. 05-________________
Do not enter your Federal Employer ID Number.

If exemption category 6 is claimed, the seller must enter the following information and sign this form below:

Description of Items Sold	Date of Seller's Original Purchase	Was tax paid when purchased by seller?	Was item depreciable?
		☐ Yes ☐ No	☐ Yes ☐ No

Section C—For Contractors Only

1. Purchase of building materials or fixtures.

☐ As an Option 1 or Option 3 contractor, I hereby certify that the purchase of building materials and fixtures from the seller listed above are exempt from Nebraska sales tax. My Nebraska Sales or Use Tax ID Number is: ________________.

2. Purchases made by an Option 2 contractor under a Purchasing Agent Appointment on behalf of ________________ (exempt entity) ________________.

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sign here Sharon Mulder — Authorized Signature | Assistant Purchasing Agent — Title | 5/3/18 — Date

Sharon Mulder — Authorized Signature Name (please print)

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