00XXX SECOND PARTY NAME

Covered Organization Affiliation Department Certification

1) **Contact information of individual who completed this form**:

Name:

Department:

Email:

Phone:

2) **Name of Covered Affiliate ("CA")**:

3) **Quality Oversight Framework**:

-Responsible Executive:

4) **Name and Brief Description of the project and affiliation with the second party**:

5) **By signing below, I hereby certify the following**:

☐ **The above CA has no responsibility or authority to operate or manage a UC facility or program on behalf of the University.**

☐ **The project will meet the following objectives (please check all that apply):**

- ☐ **Provide care to a rural or under-served regions or populations.**
- ☐ **Provide clinical training resources and opportunities to UC Davis students, residents and employees not otherwise available to them.**
- ☐ **Provide specialty services where such services are not otherwise reasonably accessible to patients.**
- ☐ **Provide affiliation and education opportunities required for licensing and certification.**
- ☐ **Provide expanded research opportunities.**

☐ **The rationale for the affiliation and its anticipated impact are as follows:**

☐ **Describe any risks and anticipated benefits to the University's education, research and public service (including patient care) missions (i.e., this affiliation will provide trainees the opportunity to experience how health care is delivered at a rural community hospital OR this CA will allow UCDH providers access to a patient population necessary to have a complete data set for their research project). Please consider one or more of the University's missions in your response: https://www.ucop.edu/uc-mission/.**

☐ **Describe any risks or anticipated benefits to the broader patient community that will result from this project (i.e., rural patients will have access to specialty services that they otherwise would lack):**

☐ **Describe the consequences of not proceeding with the project (i.e., if providers do not provide services at CA, the patients served by CA will have to travel over 100 miles to access specialty care services)**

☐ **Access to restricted services like abortion, contraception, assisted reproductive technologies, gender-affirming care, and end of life care will be:**

☐ **Maintained or improved as a result of the affiliation. By checking this box I certify that this project will not decrease community and patient access to restricted.**

If applicable, please describe any specific improvements to access to patient care that will result from this affiliation (i.e., the project will allow patients access to UCDH providers who can educate patients on all their reproductive health options):

☐ **Timely access to University (or other non-covered organization) facilities for services not provided at the CA's facility will be assured as follows:**

☐ **Any UC personnel or trainees who may be assigned to the CA have been informed or promptly will be informed: (i) that their assignment to the CA is voluntary; (ii) of the CA's restrictions on care; (iii) any requirements the CA has adopted that they certify adherence to policy-based restrictions on care; (iv) the contractual agreements that nevertheless protect their rights to counsel, prescribe, and refer, as well as to provide emergency items and services, without limitation, including any necessary items and services to any patient for whom referral or transfer to another facility would risk material deterioration to the patient's condition; (v) the expectation that they adhere to evidence-based standards of care and their professional judgment wherever they are providing services; and (vi) the identity of the office or person to whom complaints or concerns regarding care delivered or received at the CA may be directed.**

Each of the above are hereby certified by the Project Manager below:

Signature: _____

Name and Title: _____ Date: _____