



AGREEMENT

THIS AGREEMENT is made as of the 19th day of June, 2017, by and between Kenmore-Town of Tonawanda Union Free School District, having an address of 1500 Colvin Boulevard, Tonawanda, New York 14223 (the "District") and Health Works of WNY, having an address of 1900 Ridge Road, West Seneca, New York 14224 (hereinafter called the "Provider").

FOR GOOD AND VALUABLE CONSIDERATION, the sufficiency of which is hereby acknowledged, the parties agree as follows:

1. Provision of Services. Provider agrees to provide the District with the services set forth on Schedule A attached hereto and made a part hereof (the "Services"). To the extent requested by the District, the Services will be provided by the Provider at such time and location as are determined by the District.

2. Payment for Services. The District shall pay the Provider compensation and/or fees as set forth on Schedule B for the performance of the Services.

3. Term/Termination. The term of this Agreement shall be from July 1, 2017 through June 30, 2018 ("Term"). The District may terminate this Agreement by giving ten (10) days prior written notice to the Provider, and if this Agreement is terminated, no compensation will be due under paragraph 2 of this Agreement for services that were to be rendered during the period following the termination date.

4. Non-Assignability. No party shall assign, transfer or otherwise dispose of its rights or obligations under this Agreement, in whole or in part, without the prior written consent of the other party.

5. Indemnification. Provider shall indemnify, defend and hold harmless the District, its Board of Education, officers, administrators, employees, agents and representatives from and against all claims, demands, causes of action, liabilities, losses, damages, judgments, penalties, costs and expenses (including reasonable attorney fees) arising out of the negligent or intentional acts or omissions of Provider, its officers, employees, agents and representatives.

6. Insurance. During the term of this Agreement, Provider shall maintain at its own expense:

(i) a commercial general liability policy, including contractual liability coverage, in amounts of 2 million dollars per occurrence, 4 million dollars aggregate, in occurrence coverage form, naming the District as an additional insured. The District shall be an additional insured by ISO additional insured endorsement CG 20 26 or equivalent.

(ii) Workers' Compensation and New York State Disability Benefits coverage on all representatives of Provider providing services under this Agreement.

(iii) professional liability coverage for each of Provider's employees providing services under this Agreement, in amounts of 4 million dollars per occurrence, 4 million dollars aggregate. In the event that the professional liability policy is a claims made policy, Provider shall purchase a "tail" policy for a period of no less than five (5) years from the termination date of the foregoing policy. Said "tail" policy shall have policy limits in an amount not less than the primary professional liability policy.

(iv) any other insurance legally required to protect its employees, agents, independent contractors, and representatives in the performance of their duties under this Agreement.

(v) all insurance policies shall be with an insurance company acceptable to the District and additional insured endorsements shall be on a primary and non-contributory basis.

Kenmore-Town of Tonawanda Union Free School District

1500 Colvin Boulevard Kenmore, New York 14223-1196
(716) 874-8400 Fax (716) 874-8621

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Provider shall provide the District with certificates of insurance regarding all such coverage, which will provide for 30 days advance written notice to the District prior to any cancellation, non-renewal or material modification of coverage.

7. Amendment. This Agreement shall not be amended, changed, or modified in any manner except by an instrument in writing signed by a duly authorized representative of each of the parties hereto.

8. Relationship Between The Parties. The parties are independent contractors under this Agreement. Neither party shall have the authority to commit the other party to any binding obligation or to execute, on behalf of the other party, any agreement or other document creating legal obligations on the part of the other party, and neither party shall represent to any third party that it has any such authority. Provider, as an independent contractor, and Provider's personnel, shall not be considered employees of the District for any purpose. Provider is solely responsible for scheduling, directing and completing the work and for furnishing all equipment, materials, supplies, personnel, and other resources necessary to perform the work. Under no circumstances will Provider or its personnel be eligible or allowed to receive or participate in any benefit available to the District's employees. Provider will be responsible for any federal income taxes due that may be associated with the fee paid to Provider pursuant to this Agreement.

9. Miscellaneous

- a. Provider shall comply with all federal, state and local laws, rules and regulations that apply to the performance of the work.
- b. Provider represents that it (i) possesses all of the licenses, certifications and permits necessary to perform the work, and (ii) is fully qualified by training and experience to perform the work.
- c. Section 2-d of the New York State Education Law requires that a Parents Bill of Rights for data privacy and security must be included with every contract an educational agency enters into with a third party contractor, where the third party contractor receives student data or teacher or principal data. Accordingly, this Agreement is deemed to incorporate by reference the District's Parents Bill of rights for data privacy and security (*see District's website – www.ktufsd.org*). The Contractor agrees to comply with all applicable provisions of Section 2-d of the Education Law, any rules and regulations of the New York State Education Department issued thereunder, and the District's Parents Bill of Rights for data privacy and security, including any amendments to any of these.
- d. If Provider's personnel are to work with the District's students directly, all such personnel shall receive background checks through State Education procedures, if and as required by law. Proof of State Education Department clearance shall be provided prior to provision of services to the students.
- e. This Agreement shall be governed by and be interpreted in accordance with the laws of the State of New York, disputes shall be venued in a court of competent jurisdiction in Erie County, New York, and the parties hereby consent to personal jurisdiction in any such court.
- f. This written Agreement, including the attached Schedules, contains the entire agreement between the parties. There are no other agreements or understandings concerning the terms of this Agreement.
- g. In the event of conflict between Sections 1 through 9 of this Agreement and the attached Schedules, the provisions of Sections 1 through 9 of this Agreement shall prevail.
- h. This Agreement shall be binding upon and inure to benefit the executors, administrators, heirs, successors and assigns of the respective parties.

- i. Whenever any notice is to be given pursuant to the terms and conditions of this Agreement, such notice shall be in writing and shall be considered given when (i) delivered personally, or (ii) sent by commercial overnight courier with written confirmation of delivery, or (iii) when delivered by United States mail, postage prepaid, certified mail, return receipt requested, addressed to the location below, or other location as has been designated by notice in accordance with this Agreement:

The District: Kenmore-Town of Tonawanda Union Free School District
1500 Colvin Boulevard
Buffalo, New York 14223

Attention: Assistant Superintendent for Finance

Provider: Health Works of WNY
1900 Ridge Road
West Seneca, New York 14224

Attention: Richard Costanza - Director, Marketing

The parties' consent to this Agreement is indicated by their signatures below.

KENMORE-TOWN OF TONAWANDA
UNION FREE SCHOOL DISTRICT

BY:

Authorized Signatory

Health Works of WNY

BY:

Richard Costanza
Authorized Signatory

SCHEDULE A

(Services)

Provide Medical Services and Department of Transportation testing as required by law. Refer to the attached Schedule B.

SCHEDULE B

(Compensation / Fees 2017 – 2018 School Year)

19A / DOT Physical Examination including: Pre Hire/Post Hire and Annual Exam	\$57
19A / DOT 5 Panel Drug Test	\$49
Non-DOT 5 or 9 Panel Drug Test: Both tests: Photo ID required; includes random; Post accident; reasonable suspicion; split specimen Collection; testing at approved laboratory; Medical Review Officer; results reported to school	\$55
After-Hours non-Holiday Clinician Fee for Drug Screen and/or Breath Alcohol Testing (The charge(s) for the drug screen and/or breath alcohol test are billed separately)	\$160
Annual Fee for random testing program participation (based on number of enrollees)	\$780
Blood Pressure Check Only	\$14
Breath Alcohol Test (DOT and Non-DOT) With confirmation	\$31 \$31
Chest X-ray 2 view	\$90
Fitness For Duty (Brief)	\$63
Hearing / Audiogram	\$26
Hepatitis B Immunization Series of three (3) injections	\$70/inj
Medical Review of OSHA Respirator Questionnaire	\$15
On-Site Physician School Services: Including NYS mandated student physical examinations, student sports physical examinations, and Medicaid eligible referrals and examinations	\$155/hr
On-Site Provider and Clinician Services (Transportation Department)	\$40/hr (ea)
Pre-employment Physical Examination (standard exam)	\$63
PPD	\$16

SCHEDULE B (continued)

(Compensation / Fees 2017–2018 School Year)

Pulmonary Function Test	\$47
Respirator Clearance Examination	\$79
Respirator Fit Testing (Qualitative)	\$33
Workers Comp – Initial Visit:	\$83.41
Labs – varies based on service (ex., blood borne pathogen exposures)	
X-rays – varies based on type of x-ray	
Workers Comp – Follow-up exam	\$51.54



CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)
6/23/2017

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 Key Insurance & Benefits Services 726 Exchange Street Suite 900 Buffalo NY 14210	CONTACT NAME: CL Select	
	PHONE (A/C No. Ext): 877-470-6818 FAX (A/C No.): (716) 819-5140 E-MAIL ADDRESS: selectservices@key.insurance	
INSURED Healthworks Why Llp 2075 Sheridan Dr 1900 Ridge Road Kenmore NY 14223	INSURER(S) AFFORDING COVERAGE	NAIC #
	INSURER A: Hartford Ins Co/Midwest	37478
	INSURER B: Property and Casualty Ins Co of	34690
	INSURER C: Hartford Casualty Insurance Co.	29424
	INSURER D:	
	INSURER E:	

COVERAGES CERTIFICATE NUMBER: 16-17 L A E W REVISION NUMBER:

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
A	<input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: <input checked="" type="checkbox"/> POLICY <input type="checkbox"/> PROJ. <input type="checkbox"/> LOC OTHER:			01SBAAR7070	12/31/2016	12/31/2017	EACH OCCURRENCE \$ 2,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 300,000 MED EXP (Ary one person) \$ 10,000 PERSONAL & ADV INJURY \$ 2,000,000 GENERAL AGGREGATE \$ 4,000,000 PRODUCTS - COMPIOP AGG \$ 4,000,000
B	AUTOMOBILE LIABILITY <input type="checkbox"/> ANY OWNED AUTOS <input checked="" type="checkbox"/> SCHEDULED AUTOS <input checked="" type="checkbox"/> HIRED AUTOS <input checked="" type="checkbox"/> NON-OWNED AUTOS			01UBCTR0979	12/31/2016	12/31/2017	COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ PIP-Additional \$ 2,000
A	<input checked="" type="checkbox"/> UMBRELLA LIAB <input type="checkbox"/> OCCUR <input type="checkbox"/> EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE DED <input checked="" type="checkbox"/> RETENTIONS \$ 10,000			01SBAAR7070	12/31/2016	12/31/2017	EACH OCCURRENCE \$ 4,000,000 AGGREGATE \$ 4,000,000
C	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	Y/N	N/A	01WBCTN0648	12/31/2016	12/31/2017	PER STATUTE OTH-ER E.L. EACH ACCIDENT \$ 500,000 E.L. DISEASE - EA EMPLOYEE \$ 500,000 E.L. DISEASE - POLICY LIMIT \$ 500,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)
See attached Acord 101

CERTIFICATE HOLDER

Kenmore-Town of Tonawanda
Union Free School District
1500 Colvin Boulevard
Kenmore, NY 14223

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

M Bonetto/SOESTE

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ADDITIONAL REMARKS SCHEDULE

AGENCY First Niagara Risk Management, Inc		NAMED INSURED Healthworks Wny Llp	
POLICY NUMBER see page 1			
CARRIER see page 1	NAIC CODE	EFFECTIVE DATE: see page 1	

ADDITIONAL REMARKS

THIS ADDITIONAL REMARKS FORM IS A SCHEDULE TO ACORD FORM,
FORM NUMBER: 25 FORM TITLE: Certificate of Liability

to extent covered by endorsement form(s):

Business Liability Coverage Form:

- SS 00 08 (04/05) Additional Insured when required by written contract
- SS 12 23 (06/11) Notice of Cancellation to Certificate Holder
- SS 00 08 (04/05) Waiver of Subrogation



CERTIFICATE OF INSURANCE COVERAGE UNDER THE NYS DISABILITY BENEFITS LAW

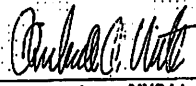
PART 1. To be completed by Disability Benefits Carrier or Licensed Insurance Agent of that Carrier

<p>1a. Legal Name and Address of Insured (Use street address only) HEALTHWORKS -WNY LLP</p> <p>1900 RIDGE ROAD WEST SENECA, NY 14224</p>	<p>1b. Business Telephone Number of Insured</p> <p>1c. NYS Unemployment Insurance Employer Registration Number of Insured</p> <p>1d. Federal Employer Identification Number of Insured or Social Security Number 161614035</p>
<p>2. Name and Address of the Entity requesting Proof of Coverage (Entity being listed as the Certificate Holder) Kenmore-Town of Tonawanda Union Free School District</p> <p>1500 Colvin Boulevard Kenmore, NY 14223</p>	<p>3a. Name of Insurance Carrier ShelterPoint Life Insurance Company</p> <p>3b. Policy Number of Entity listed in box "1a": DBL289375</p> <p>3c. Policy effective period: 01/01/2017 to 12/31/2017</p>

4. Policy covers:

- a. All of the employer's employees eligible under the New York Disability Benefits Law
- b. Only the following class or classes of the employer's employees:

Under penalty of perjury, I certify that I am an authorized representative or licensed agent of the insurance carrier referenced above and that the named insured has NYS Disability Benefits insurance coverage as described above.

Date Signed 6/23/2017 By 
(Signature of insurance carrier's authorized representative or NYS Licensed Insurance Agent of that insurance carrier)

Telephone Number 516-829-8100 Title Chief Executive Officer

IMPORTANT: If box "4a" is checked, and this form is signed by the insurance carrier's authorized representative or NYS Licensed Insurance Agent of that carrier, this certificate is COMPLETE. Mail it directly to the certificate holder.
If box "4b" is checked, this certificate is NOT COMPLETE for the purposes of Section 220, Subd. 8 of the Disability Benefits Law. It must be mailed for completion to the Worker's Compensation Board, DB Plans Acceptance Unit, 328 State Street, Schenectady, NY 12305.

PART 2. To be completed by NYS Worker's Compensation Board (Only if box "4b" of Part 1 has been checked)

**State of New York
Worker's Compensation Board**

According to information maintained by the NYS Worker's Compensation Board, the above-named employer has complied with the NYS Disability Benefits Law with respect to all of his/her employees.

Date Signed _____ By _____
(Signature of NYS Worker's Compensation Board Employee)

Telephone Number _____ Title _____

Please Note: Only insurance carriers licensed to write NYS Disability Benefits insurance policies and NYS Licensed Insurance Agents of those insurance carriers are authorized to issue Form DB-120.1. Insurance brokers are NOT authorized to issue this form.

Additional Instructions for Form DB-120.1

By signing this form, the insurance carrier identified in box "3" on this form is certifying that it is insuring the business referenced in box "1a" for disability benefits under the New York State Disability Benefits Law. The Insurance Carrier or its licensed agent will send this Certificate of Insurance to the entity listed as the certificate holder in box "2".

Will the carrier notify the certificate holder within 10 days of a policy being cancelled for non-payment of premium or within 30 days if cancelled for any other reason or if the insured is otherwise eliminated from the coverage indicated on this certificate prior to the end of the policy effective period? YES NO

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 policy listed, nor does it confer any rights or responsibilities beyond those contained in the referenced policy.

This certificate may be used as evidence of a Disability Benefits contract of insurance only while the underlying policy is in effect.

Please Note: Upon the cancellation of the disability benefits policy indicated on this form, if the business continues to be named on a permit, license or contract issued by a certificate holder, the business must provide that certificate holder with a new Certificate of NYS Disability Benefits Coverage or other authorized proof that the business is complying with the mandatory coverage requirements of the New York State Disability Benefits Law.

DISABILITY BENEFITS LAW

§220. Subd. 8

(a) The head of a state or municipal department, board, commission or office authorized or required by law to issue any permit for or in connection with any work involving the employment of employees in employment as defined in this article, and notwithstanding any general or special statute requiring or authorizing the issue of such permits, shall not issue such permit unless proof duly subscribed by an insurance carrier is produced in a form satisfactory to the chair, that the payment of disability benefits for all employees has been secured as provided by this article. Nothing herein, however, shall be construed as creating any liability on the part of such state or municipal department, board, commission or office to pay any disability benefits to any such employee if so employed.

(b) The head of a state or municipal department, board, commission or office authorized or required by law to enter into any contract for or in connection with any work involving the employment of employees in employment as defined in this article and notwithstanding any general or special statute requiring or authorizing any such contract, shall not enter into any such contract unless proof duly subscribed by an insurance carrier is produced in a form satisfactory to the chair, that the payment of disability benefits for all employees has been secured as provided by this article.