June 15, 2023

Chris McCartt
City Manager
City of Kingsport
415 Broad Street
Kingsport, TN 37660
(423) 229-9400

Re: Letter of Agreement for Physical Wellness/Strengthening Program

I am pleased to present this Letter of Understanding to the City of Kingsport ("City of Kingsport") and initiating a relationship between our entities. Champion Physical Therapy, LLC ("CORA") would like to outline the services City of Kingsport may expect to receive in exchange for providing the services hereunder:

CORA Responsibilities:

- CORA shall provide a physical wellness and strengthening program for City of Kingsport employees, as requested by City of Kingsport.
- CORA shall provide these services during normal business hours at the CORA Physical Therapy Kingsport location (1825 N. Eastman Rd., Suite A Kingsport, TN 37664)
- CORA will require scheduled appointments for initial assessments as well as follow up appointments to be scheduled directly at the facility either in person or via phone (423) 390-8948
- CORA shall provide qualified Physical Therapists (PT), Physical Therapy Assistants (PTA), and or Athletic Trainers (ATC) educated in the field of rehabilitation and licensed by their respective licensing boards, who maintain an unlimited license to practice.
- CORA shall provide access to MedBridge (the mobile platform that maintains their exercise program and progression) to employees during the initial assessment.
- CORA shall bill City of Kingsport $46/assessment and/or training session.
- CORA shall submit monthly invoices via email (michaelwessely@kingsporttn.gov) to the City of Kingsport Attn: Michael Wesley to include itemized documentation of the date of service, employee name, and employee job title.
- CORA shall not refuse to provide services to any employee on the grounds of race, color, sex, age, disability or national origin.
- CORA will maintain public liability and medical malpractice insurance in the minimum amount of One Million Dollars ($1,000,000.00) for each occurrence and Five Million Dollars ($5,000,000.00) in the aggregate.
- CORA shall indemnify and hold City of Kingsport harmless from claims or causes of action from clients or third parties resulting from acts or omissions of CORA in performing all services hereunder.
- CORA shall acknowledge and maintain its obligations to comply with the provisions of the Health Insurance Portability and Accountability Act ("HIPAA").

City of Kingsport Responsibilities:

- City of Kingsport will reimburse CORA $46/assessment and/or training session.
- City of Kingsport will pay CORA within 30 days of receipt of invoice from CORA

BINDING AGREEMENT

CORA and City of Kingsport agree that this Letter of Understanding is intended to create a binding obligation of the parties once signed by both parties.

If the foregoing accurately reflects your understanding, please date, sign and return the enclosed copy of this Letter of Understanding. In the event you do not accept this Letter of Understanding by July 15, 2023 the promise hereof will be null and void. We look forward to establishing this relationship with you.

CHAMPION PHYSICAL THERAPY, LLC

By: _____

Title: _____

CITY OF KINGSPORT

By: _____

Title: _____

Accepted this ____day of _____, 2023

INFORMED CONSENT AGREEMENT

Thank you for choosing to use the facilities, services, or programs of the CORA Fitness Program ("CFP"). We request your understanding and cooperation in maintaining both your and our safety and health by reading and signing the following consent agreement.

I, the undersigned, declare that I intend to use some or all of the activities, facilities, programs and services offered by CFP and understand the each person (myself included) has a different capacity for participating in such activities, facilities, programs and services. I am aware that all activities, services and programs offered are educational, recreational or self-directed in nature. I assume full responsibility during and after my participation for my choices to use or apply, at my own risk, any portion of the information or instruction I receive.

I understand that part of the risk involved in undertaking any activity or program is relative to my own state of fitness or health (physical, mental, or emotional) and to the awareness, care and skill with which I conduct myself in that activity, service and program. I acknowledge that my choice to participate in any activity, service and program of CFP bring with it my assumption of those risks or results stemming from this choice and the fitness, health, awareness, care and skill that I possess and use.

I further understand that activities, programs and services offered by CFP are sometimes conducted by personnel who may not be licensed, certified, registered instructors or professionals. I accept the fact that the skills and competencies of some employees and/or volunteers will vary according to their training and experience and that no claim is made to offer assessment or treatment of any medical or physical disease or condition by those who are not duly licensed, certified or registered and herein employed to provide such professional services.

I recognize that by participating in the activities, facilities, programs and services offered by CFP, I might experience potential health risks such as transient light-headedness, fainting, abnormal blood pressure, chest discomfort, leg cramps and nausea and that I assume those risks willfully. I acknowledge my obligation to immediately inform the nearest supervising employee of any pain, discomfort, fatigue or any other symptoms that I may suffer during and immediately after my participation. I also understand that I may stop or delay my participation in any activity or procedure if I so desire and that I may also be requested to stop and rest by a supervising employee who observes any symptoms of distress or abnormal response.

I understand that I may ask any questions, request further explanation or information about the activities, facilities, programs and services offered by CFP at any time before, during or after my participation.

I CERTIFY THAT I HAVE NO MEDICAL CONCERNS THAT WOULD AFFECT MY PARTICIPATION IN THE PROGRAM AND THAT MY PHYSICIAN IS AWARE OF AND CONSENTS TO MY PARTICIPATION.

I declare that I have read, understand and agree to the contents of this informed consent agreement in its entirety.

Signature: _____ Date: _____/_____/_____

Witness: _____