Regional Medical Center
Excellence in healthcare, close to home

COVID- 19 Student Requirements, Assumption of Risk, and Release and Waiver of Liability

******Every student must complete this form prior to their arrival at Regional Medical Center or any of its associated Clinics ("Facility")******

By initialing and signing this informed Consent Agreement, I acknowledge, accept, and agree to the following:

_____ Donning & Doffing PPE Safely training has been completed on _____/_____/_____
(Date of completion)

_____ I will not attend Clinical if any of the following apply:

a. Myself, or any member of my household, is exhibiting symptoms of illness, such as cough, fever, sore throat, or shortness of breath.
b. Myself, or any member of my household, has been diagnosed with COVID-19 or has [1] a suspected diagnosis of COVID-19.
c. Myself, or any member of my household, has spent time with another individual with a diagnosis of COVID-19 or has a suspected diagnosis of COVID-19.

_____ I agree to immediately inform my preceptor, Facility contact, and instructor at my college/university if I or any member of my household has been diagnosed with COVID-19 or has a suspected diagnosis of COVID-19.

_____ I agree to inform my preceptor, Facility contact, and my instructor at my college/university immediately if I begin to feel unwell at any time during my rotation.

_____ I have not traveled out of the United States in the last 14 days and will not do so during my rotation.

_____ I am aware that I may be exposed to COVD-19 while participating in Clinical or meetings at the Facility. I understand that this exposure carries a risk of infection, serious injury, or death.

_____ I agree to assume all risks of infection, injury, or death, whether those risks are known or unknown.

_____ I agree to abide by daily Facility screening procedures, which may include temperature checks upon entering the Facility, questions relating to COVID-19 exposure, travel, etc.

_____ I understand that there may be restrictions due to shortages of PPE that may affect my Clinical rotation experience.

[1] "COVID-19" is also known as coronavirus disease 2019, or 2019-nCoV, or novel coronavirus.

_____ I agree that my college/university has provided me with the knowledge and skills needed to keep myself safe in my Clinical rotation.

_____ I understand that there may be additional training that may be required by the Facility regarding daily PPE usage and processes implemented due to COVID-19.

_____ I understand that my rotation scheduling may change or even be canceled at any time due to unforeseen circumstances related to COVID-19.

_____ I, on behalf of myself, my personal representatives, heirs, executors, administrators, agents, and assigns, **HEREBY RELEASE, WAIVE, DISCHARGE, AND COVENANT NOT TO SU**E Regional Medical Center or Clinics, their agents, employees, staff, directors, or officers ("Releases) for any and all liability, including any and all claims, demands, causes of action (known or unknown), suits, or judgments of any and every kind (including attorneys' fees) arising from injury or death that I may suffer as a result of my participation in Clinical.

I HAVE CAREFULLY READ THIS AGREEMENT AND FULLY UNDERSTAND ITS CONTENTS. I AM AWARE OF THE RISKS OF CLINICALS DURING THE COVID-19 PANDEMIC. I AM AWARE THIS FORM CONTAINS A RELEASE AND WAIVER OF LIABILITY.

_____ _____

Student Signature Date

_____ _____

Name (Print Legibly) University/College (Print Legibly) Page