West Virginia University
Rural Shadowing in Healthcare Program Release Form

Please list all known allergies or indicate None**:** _____
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Please read the following statements and check the box next to the statement if you agree that the statement is accurate:

- I am at least 18 years of age
- I have reviewed the "Information for Rural Undergraduate Shadowing in Healthcare Participants" document and agree to abide by all policies stated within the document
- The following immunizations are up-to-date for me:
  - MMR (Measles, Mumps & Rubella). Positive antibody levels for this will also be acceptable.
  - History of Varicella or Varivax (Chicken Pox or Chicken Pox Vaccine)
  - Tetanus/Tdap
  - Influenza vaccine within the past 12 months
  - Negative PPD tuberculosis skin test within the past 30 days
- I will only participate in the Rural Undergraduate Shadowing in Healthcare experience if free from infectious disease during the scheduled 20-hour period of the program.
- I have completed all of the required CITI training modules
- I will follow all WVU and [Health Care Center] rules and regulations including maintaining patient privacy in accordance with the Health Insurance Portability and Accountability Act.
- I agree to complete any additional training and/or screening requirements if requested by the health care center at which I will be visiting prior to starting my shadowing experience
- I understand that I shall not and am not permitted to engage in the practice of medicine, dentistry, or an allied health profession field.
- I may be permitted by a physician, dentist, or allied health professional with privileges at the participating health care center to observe interactions with a patient, be present for the examination of a patient, and/or be present in an operating/procedure room for a procedure of a patient. I agree and understand that I may engage in the above observational activities **ONLY** in the presence of a physician, dentist, or allied health professional with privileges at the participating health care center. I will only be permitted to observe these activities; I will not be permitted to participate in any patient care.

- I shall NOT at any time participate in a surgical case or procedure while observing an operating/procedure room, or write in, dictate or otherwise cause an entry to be made in a patient's chart

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Signature of Applicant Date Print Name

Authorization/Release of Liability

I certify that I have reviewed the "Information for Rural Undergraduate Shadowing in Healthcare" and agree to abide by all standards and expectations.

I shall and do hereby agree to indemnify and save WVU and [Health Care Center], its directors, officers, employees, agents, servants, successors, and assigns harmless from any and all claims, demands, causes of action, liability damages, or loss, including reasonable attorney's fees and defense costs, which WVU and [Health Care Center] may at any time sustain or incur by reason of any act or omission to act arising out of or related to my participation in the Rural Undergraduate Shadowing in Healthcare experience.

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Participant's Signature Date Printed Name