

## **Agreement and Release and Waiver From Liability**

### **Policies & Procedures**

I \_\_\_\_\_ understand that Pitt County Memorial Hospital has agreed to allow me access to various clinical settings. While I am on the Agency's site, I must follow all policies and procedures. I have been informed of these policies and procedures. Any questions I had regarding them have been answered fully.

### **Infection Control**

I do not, to the best of my knowledge, have an infectious disease or a contagious health problem that might or could risk a patient's or employee's health at Agency. I agree to immediately notify Agency if I contract or become aware that I have a health problem that might or could put at risk a patient's or employee's health at Agency.

### **Confidentiality**

I agree to not repeat or share confidential (private) patient information as required by related state and federal laws. This includes patient name, health related information or any patient specific information I come in contact with during my shadowing experience.

I will only make known this information as allowed by law after contacting the agency contact person.

### **Criminal Background**

I have never been found guilty or plead nolo contendere (I do not wish to contend) to any felony and/or to any other offense. This includes violence, injury to person, destruction of property, sexual offenses, drugs, theft or moral turpitude. I do not have any pending criminal charges against me. This includes any felony offense or any offense involving violence, injury to person, destruction of property, sexual offenses, drugs, theft or moral turpitude. During my presence at Agency, I agree to advise Agency of any changes in my criminal record.

**Agreement and Release and Waiver  
From Liability**

**Liability**

I voluntarily release Pitt County Memorial Hospital, its successors, assigns, and affiliates and its directors, officers, agents, and employees from all liability for any claim or cause of action, I, my heirs, or assigns, might now or hereafter have for injury, loss, damage, or death arising out of, or incident to, my presence in clinical settings. I agree to hold Agency harmless from all claims, losses, liability, and demands that may be realized due to my negligence, gross negligence, willful misconduct, or violation of this Agreement. I understand that the privilege of being allowed to participate depends on my executing and complying with this Agreement. I understand that this privilege may be revoked or modified at any time without cause or prior notice at the Agency's sole discretion. I have read and understand this Agreement and Waiver and Release From Liability.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date