Maimonides
Medical Center

HEALTHCARE PATHWAYS PROGRAM

RELEASE AND INDEMNIFICATION AGREEMENT FOR APPLICANTS 18 YEARS OF AGE AND OLDER

Participant:

_____
Name

_____
Address

_____

_____
Date of Birth

I am the above-named Participant who is eighteen years of age or older and I am fully competent to sign this Agreement. I understand that I have been selected to participate in the Healthcare Pathways Program (the "Program"), an educational internship in the Emergency Department at Maimonides Medical Center (the "Medical Center"). I agree to participate in the Program. I understand and acknowledge that in participating in the Program, I will be exposed to the normal risks of any hospital visitor as well as possible additional risks that arise because I will be in patient care areas, including procedure rooms. In addition to being an Emergency Department in a tertiary care hospital, the Medical Center is a Level 1 Trauma Center for Adults and Pediatrics, a Cardiac and Stroke Center, and has a Psychiatric Emergency Department. As such, I expect to observe patients in critical or unstable condition and in a state well out of the norms of what is usually encountered in everyday life, and I am aware that some of what I observe may be psychologically disturbing.

In the event of exposure to blood or other bodily fluids from a patient who is a carrier of a contagious or infectious disease or a patient who is, in the judgment of the Medical Center, at risk of carrying a contagious or infectious disease, the Medical Center may administer immediate precautionary treatment to Participant consistent with current medical practice without any further consent from me. I agree that I am financially responsible for any initial screening tests or prophylactic medical treatments should the need arise. The Medical Center shall have no responsibility for any further diagnosis, medication or treatment and I acknowledge and assume the risk of observing or being in the immediate presence of patients at risk of carrying a contagious or infectious disease.

In consideration of Participant being permitted to participate in the Program, I hereby release the Medical Center, its Trustees, officers, employees, volunteers and agents from any and all liability to Participant, Participant's personal representatives, estate, heirs, next of kin, and assigns for any and all claims and causes of action for loss of or damage to Participant's property and for any and all illness or injury to Participant's person, including his/her death, that may result from or occur during Participant's participation in the Program, even if caused by negligence of the Institution, its trustees, officers, employees, volunteers or agents. I further agree to indemnify and hold harmless the Institution and its trustees, officers, employees, and representatives from liability for the injury or death of any persons and damage to property that may result from Participant's negligent or intentional acts or omissions while participating in the referenced Activity.

Signature: _____ Print Name: _____ Date: _____	Address (if different from above): _____ _____