



**Agreement and Liability Waiver
In Conjunction with Your Experience at Great River Health System, Inc.**

For experiential value received, and upon signing and submitting this Agreement and Waiver, I confirm that I wish to participate in an observational experience at Great River Health System, Inc., Southeast Iowa Regional Medical Center, Henry County Health Center and its associated clinics. I confirm and acknowledge that Great River Health System's observational experience is voluntarily offered and provides to me an uncompensated opportunity to me to further my education and training. I understand that the term of this agreement is applicable during the Semester designated below.

Name of Student: _____

School: _____

Dates of Observational Experience (check one): _____ Spring _____ Fall _____ Summer in Year: _____

I agree to abide by Great River Health System's policies and procedures, as well as all state, federal, and local laws. I also understand that since my observational experience at Great River Health System is voluntary, either Great River Health System's or I may terminate it at any time, with or without cause, regardless of any agreements in conjunction with my Observational experience, application or contract. I understand and accept that Great River Health System cannot and does not guarantee that any or all observational experience or learning goals and objectives will be achieved.

Risk Acknowledgement:

I understand that my observational experience by being in a healthcare setting exposes me to risk of bodily injury, property damage, or death, and I accept and fully understand these risks.

Insurance:

I understand that as a "non-employee", Great River Health System does not provide employee benefits such as health insurance or workers compensation coverage to students participating in an observational experience, and understand that I am responsible for obtaining and sustaining my own health/medical as well as any related professional liability policies.

Liability Waiver and Indemnification:

Furthermore, in consideration of the observational experience afforded me, with full knowledge and appreciation of the risks involved, I hereby agree to indemnify, release and hold harmless Great River Health System, Inc., Southeast Iowa Regional Medical Center and its associated clinics, their respective staff, trustees, officers, representatives, and agents, from all form and manner of risks inherent or relating to such activities connected to my observational experience, and I waive all claims and demands of any nature arising from my observational experience. I agree and understand that this liability waiver and indemnification will extend beyond the dates of this agreement and observational experience.

HIPAA and Confidentiality:

I have reviewed the Great River Health System orientation materials which cover among other topics patient confidentiality and the federal HIPAA requirements. I understand the content of those materials and have had an opportunity to ask questions about any of the material that I may not have understood.

I hereby acknowledge that I have had the opportunity to review this form and have it reviewed by legal counsel if I deem necessary. I understand the foregoing and hereby agree to be bound by same. I agree to comply with Great River Health System and federal requirements relating to confidentiality of patient information and HIPAA.

Signature of Student: _____ Date: _____

Print Full Legal Name of Student: _____