Clinical Agreement

WHEREAS, the curriculum of the _____ (academic program) of _____ (academic institution) requires substantial clinical work which can only be completed in a healthcare facility;

WHEREAS, University Health Services, Inc. d/b/a University Hospital, has agreed with the academic institution to permit such clinical work at University Hospital;

WHEREAS, students of the academic institution are not employees of University Health Services, Inc., and

WHEREAS, University Health Services, Inc. is not obligated to and will not provide workers compensation benefits to students engaged in clinical work/training at University Hospital;

THEREFORE, in consideration of University Health Services, Inc., allowing me to use University Hospital facilities to complete the clinical portion of that curriculum, I agree, regardless of the theory of liability pursued or the nature and extent of any damages I may suffer, that in no event will I be entitled to a recovery from University Health Services, Inc., for any damage I suffer while engaged in clinical work at University Hospital.

I understand that and intend this agreement to be a limitation upon my rights to recover damages based upon common law, the statutes of Georgia, the statues of the United States, or any other theory in law or in equity.

I understand the sole obligation of University Health Services, Inc. is to allow me to use the facilities of University Hospital pursuant to the terms and conditions of the Agreement between _____ (academic institution) and University Hospital.

I understand that I will be required to have an annual complete Level 1 background check (to include criminal state, federal and sex offender registry) and an 8 panel urine drug screen. The results of the background check and drug screen shall be solely reviewed by the Facility. I understand that if my results fail to meet the Facility's standards on these tests, I may be rejected or automatically withdrawn from participation in the Program at the Facility at the Facility's sole discretion and request. No information regarding the specific deficiencies of a Student's test results or background check shall be shared with the College.

I attest that I have been provided, have reviewed, understand, and agree to abide by the information and policies provided in the University Hospital Student Orientation Presentation.

I agree to abide by the confidentiality guidelines as provided by University Hospital and the HIPAA statement.

I understand that failure to follow any University Hospital policy can result in termination of my clinicals at this facility.

Instructor's or Student's Name:

_____ _____

(Please Print Name) (Date)

_____

(Signature)