

MEMORANDUM OF UNDERSTANDING FOR SUPERVISED PRACTICE EXPERIENCE (APPENDIX B)

This Memorandum of Understanding between Fraser Health (FH) and *(name of individual)* Click here to enter text.of *(name of organization, if applicable)* Click here to enter text. is entered into for the purpose of clarifying the responsibility assumed by the FH staff member, *(name of employee)* Click here to enter text. participating in a ‘Supervised Practice Experience’ of limited duration, not affiliated with a formal educational institution, and requiring supervised practice in order to fulfill admission to or licensure by a professional college. Failure to maintain or comply with any of the following may result in termination of the experience.

# THE INDIVIDUAL AND FH AGREE THAT:

**1.** **The individual’s responsibilities are to**:

1. Comply with the standards of practice, policies and procedures established by FH, particularly those involving patient confidentiality and patient safety. Including signature of the FH Confidentiality Agreement.
2. Upon request, supply evidence of current immunizations of concern to the Individual’s Supervisor.
3. Take reasonable measures to avoid exposure to any hazard or risk of harm.
4. Respect the clients’ right to privacy, and defer to any wish by a client or care provider that the individual not attend particular episodes of care.
5. Refrain from direct client care of any nature except under supervision by the FH supervising staff member and when it is within scope of practice.
6. Assume all responsibility for the quality of instruction and for ensuring that all curricula, supervisors, and instructors meet the requirements of the professional college.
7. The individual shall indemnify and save harmless FH from and against all liability including, but not limited to claims, losses, damages, judgments, costs, expenses, actions and other proceedings made, incurred, sustained, brought, prosecuted or threatened to be brought or prosecuted that are based upon, occasioned by or arising out of any act, error, deed, matter, thing, negligence or omission on the part of the Individual arising out of this Agreement, and agrees to maintain third party liability coverage to a minimum of $2 million, naming FH as an additional insured. A current copy of this certificate is to be kept on file at FH during the course of this agreement.

**2.** **Fraser Health’s responsibilities are to**:

1. Provide the individual with a desirable supervised practice experience within the scope of health care services provided at this facility.
2. Maintain the quality of client care while offering the individual an opportunity to learn.
3. Identify a liaison person with whom communications and feedback regarding the experience can be channeled.
4. Make available to the individual the information necessary to comply with the facility’s policies and procedures, especially those related to patient confidentiality and safety.
5. Provide and maintain comprehensive general liability insurance.

**3.** **The parties agree that:**

1. While in an FH facility, the individual shall be and remain an independent student and in no sense be considered an employee or agent of FH.
2. There is no coverage for Work Safe BC type injuries sustained during the experience. FH assumes no liability for injuries sustained by the individual. The individual has been advised of the recommendation to maintain personal injury (death and disability) insurance to a minimum of $500,000 and (**initial one**):

Click here to enter text. has agreed to do so, and provide evidence of same

Click here to enter text. has decided not to, confirming that FH assumes no liability for injuries, and will not be held responsible (complete *Waiver and Release of Responsibility* form {attached to this document})

Date(s) of Supervised Practice: Click here to enter text.

Profession/Professional College of Individual: Click here to enter text.

Name of FH Supervisor/Manager/Lead: Click here to enter text.

Signature of FH Supervisor/Manager/Lead: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date *(d/m/y)*: Click here to enter text.

Practice Area/Site: Click here to enter text. Site/Location: Click here to enter text.

**INDIVIDUALS RELATIONSHIP WITH FRASER HEALTH:**

Click here to enter text. Employed Staff

Click here to enter text. Medical Staff

Click here to enter text. Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signed at (city) Click here to enter text. this Click here to enter text. day of Click here to enter text. 20 Click here to enter text.

**NAME OF INDIVIDUAL SIGNATURE OF INDIVIDUAL**

Click here to enter text.

Name Signature

**NAME OF WITNESS SIGNATURE OF WITNESS**

Click here to enter text.

Name Signature

**WAIVER AND RELEASE OF RESPONSIBILITY**

**THIS DOCUMENT AFFECTS YOUR LEGAL RIGHTS AND LIABILITIES - PLEASE READ CAREFULLY**

The Fraser Health Authority (hereinafter called Fraser Health) requires students to have accident insurance coverage as a condition of participating in a supervised practice experience. In consideration of the benefits to be achieved by facilitating a supervised practice experience (hereinafter called “experience”) and the risks associated with the applicant not having accident insurance coverage for the duration of this placement, Fraser Health has drawn up this waiver and release of responsibility.

**DISCLAIMER CLAUSE:**

The Fraser Health Authority (Fraser Health) is not responsible for any injury or damage suffered by *(name of individual)* Click here to enter text. arising from or related to his/her in the *(practice area)* Click here to enter text. of Fraser Health, located at *site(s)* Click here to enter text..

**AGREEMENTS:**

I *(name of individual)* Click here to enter text. hereby acknowledge and agree that I am not an agent, employee or servant of Fraser Health for the purposes of this experience.

I acknowledge that I wish to participate in this experience in the *(department/practice area)* Click here to enter text. and I hereby accept full responsibility for and assume all risks for myself and waive any responsibility or duty that Fraser Health may have in these circumstances.

In consideration of Fraser Health permitting this experience, I hereby release Fraser Health, its Directors, officers, employees, agents and attending physicians from any and all liability for any loss, injury or damage, which I may suffer during the course of my supervised practice experience with Fraser Health.

I acknowledge and agree that I will abide by the applicable policies and procedures of Fraser Health and follow the directions and instructions of duly authorized employees of Fraser Health.

I acknowledge that I am nineteen (19) years of age or over, and I have read this Liability Release and I accept the above Disclaimer Clause as evidenced by my signature.

Signed at (city) Click here to enter text. this Click here to enter text. day of Click here to enter text. 20Click here to enter text.

**NAME OF INDIVIDUAL SIGNATURE OF INDIVIDUAL**

Click here to enter text.

Name Signature

**NAME OF WITNESS SIGNATURE OF WITNESS**

Click here to enter text.

Name Signature

\*form adapted from Interior Health Authority March 1, 2017

All completed forms are to be returned to the Manager/Practice Lead for the program/site