**MEMORANDUM OF UNDERSTANDING FOR SUPERVISED PRACTICE EXPERIENCE**

**ATTACHMENT 1**

**WAIVER AND RELEASE OF RESPONSIBILITY**

**THIS DOCUMENT AFFECTS YOUR LEGAL RIGHTS AND LIABILITIES**

**PLEASE READ CAREFULLY**

**DISCLAIMER CLAUSE:**

Fraser Health Authority (Fraser Health) is not responsible for any injury or damage suffered by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (insert your name), arising from or related to my supervised practice experience as \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (insert nature of your experience) with Fraser Health.

**LIABILITY RELEASE:**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (insert your name), understand, 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, and I hereby accept full responsibility for, and assume all risks for, myself and waive any right of recovery from Fraser Health that I may otherwise be entitled to at law during this experience.

In consideration of Fraser Health permitting me to participate in the supervised practice 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 that I have read the applicable Fraser Health policies and procedures, and agree that I will abide by all applicable Fraser Health policies and procedures, and follow the directions and instructions of duly authorized employees of Fraser Health.

I acknowledge and agree that the electronic transmission of my signature will be deemed to constitute my original signature with the same force and effect as if I delivered my original signature.

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

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Print Your Full Legal Name Your Signature**

**Date (dd/mm/yy): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Your Full Address, including postal code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your Telephone Number(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FOR LEADER (OR DESIGNATE):

☐ Ensure that Waiver and Release of Liability form has been fully completed and signed by SPE Candidate.

☐ Provide copy of signed Disclaimer Clause and Waiver and Release of Liability to SPE Candidate.

☐ Send copies of the signed forms and supporting documentation to Professional Practice (student.placement@fraserhealth.ca).