PARENT/GUARDIAN OF MINOR OR STUDENT WAIVER

Clinical research experiences in a health care setting assume certain risks, including the possibility of exposure to an infectious disease, environmental hazard, injury from equipment or medical materials, and illness or injury to oneself, employees, patients or visitors. I understand that University Hospitals Health System and the Facility site where I am assigned for my Experience (together or separately, "UH"), and their affiliates do not provide any accident, malpractice, health, medical, or workers' compensation insurance coverage for any illness or injury I may acquire or cause at UH. I understand and agree that I waive, for myself or any heirs and/or assigns, any and all claims which I might have against UH, or its agents or representatives, in any way resulting from personal injuries, illness, or property damage sustained by me and arising out of participation in the Experience at UH, except for claims arising out of the gross negligence or reckless or willful misconduct of UH or its employees.

In the event I am exposed to a contagious or infectious disease or a patient who is, in the judgment of UH, at risk of carrying a contagious or infectious disease, UH shall, if indicated and with my consent, either administer immediate precautionary treatment consistent with current medical practice or, depending on the circumstances, refer me to an emergency or urgent care facility, for immediate precautionary treatment. I shall pay for the initial screening tests or prophylactic medical treatments. UH shall have no responsibility for any further diagnosis, medication or treatment and I acknowledge and assume the risk of working with patients at risk of carrying a contagious or infectious disease, except for the risk of gross negligence or willful or reckless misconduct on the part of UH, its trustees, officers, agents, and employees.

CONFIDENTIALITY AND NON-DISCLOSURE AGREEMENT

It is understood that in the performance of my duties, I may obtain confidential information about or from UH ("Confidential Information"). Confidential Information includes, but is not limited to, financial or proprietary data about UH, information about UH's business and employees, patient information, methods of operating, development plans, programs, documentation, techniques, trade secrets, systems, know-how, policy statements and other confidential data. I will not disclose Confidential Information (including, but not limited to, protected health information ("PHI")) to anyone, including my family and friends, under any circumstances. I agree to maintain in strict confidence all Confidential Information and will not, unless otherwise required by law, disclose such Confidential Information to any third party without UH's prior written consent. Prior to discussion of or writing about any UH patient in an academic context relative to my Experience, all individually identifiable information will be removed.

I agree to maintain patient confidentiality in both written and verbal communication with other students, instructors, any other individuals, in class discussion, as well as in any published materials. I understand that patient confidentiality is of such great importance that PHI is NEVER to be shared with anyone even if it is years after I participate in the Experience.

"PHI" is defined as individually identifiable health information, which is health information created, received or used by UH relating to (a) the past, present or future physical or mental health or condition of a patient, or (b) payment for the provision of healthcare to a patient. PHI contains identifiers that identify a patient or for which there is a reasonable basis to believe the information can be used to identify a patient. Examples of individual identifiers include, but are not limited to, patient name, complete addresses, social security number, date of birth, medical record number and dates of treatment. PHI may include any or all of these individual identifiers coupled with a patient's health information, examples of which are a social security number and diagnosis, date of birth and past medical history, or dates of treatment and symptoms present at the time of treatment.

I understand and agree that this signed Exhibit A shall remain effective for the duration of my or my child's Experience at UH.

Signed: _____ Date: _____

_____ School: _____

Printed Name of Student or Parent/Guardian of Minor

UH TO RETAIN THIS SIGNED EXHIBIT FOR AT LEAST SIX YEARS PER UH P&P GM-1