CARILION CLINIC

Participation Agreement

I am participating in various practical, clinical, and/or observational experiences (Education Experience) either (i) through a school which has entered into a Student Program Agreement to do observation or clinical participation with the Provider, or (ii) through an independent Educational Experience approved and accepted by the Provider pursuant to this Agreement.

Policies and Procedures: In consideration of my acceptance into said Educational Experience, I understand and agree that while participating in the Educational Experience, I am subject to all of the Provider's rules, policies and procedures, including those relating to appearance and behavior. I further understand and agree that I may be required to withdraw from the Educational Experience if my performance is unsatisfactory; or if I fail to comply with said rules, policies, and procedures; or if my health status, taking into account all reasonable accommodations, is a detriment to my successful completion of the Educational Experience.

Confidentiality: I understand and agree that the services the Provider performs for its patients and the information patients furnish to it are highly confidential. It is the Provider's obligation and policy to protect the patient's right to privacy and to maintain the confidentiality of all patient medical records, including the identity of patients, the services performed for them, and all information concerning their affairs (hereafter referred to as the "Patient Information"). Provider's good will depends upon, keeping such patient information confidential.

In addition to Patient Information, I acknowledge that the Provider's operation, policies, procedures and records constitute important business assets and are confidential. Such records include, but are not limited to personal records, strategic plans, policy and procedure manuals, bookkeeping and other accounting information, and all such documents and records related to Provider's business activity (hereinafter referred to as "Business Information").

By reason of my participation in the Educational Experience, I may come into possession of Patient Information or Business Information. I understand and agree that the Patient Information and Business Information obtained by me during my participation in the Educational Experience shall not be revealed to anyone without the signed written authorization from the patient or guardian in the case of Patient Information or from the Provider in the case of Business Information. I agree not to permit anyone to examine or make copies of any Patient Information or Business Information that may come into my possession.

Assumption of Risks: As a participant in the Educational Experience, I may be allowed to observe or, where applicable to the Educational Experience, participate in clinical activities in patient care areas, including high risk patient care areas such as the Emergency Department or Adult Special Care Units. I understand that in such high-risk patient care areas that Provider's policies may restrict my activities and observation may be limited to certain specified areas.

I understand that there are risks and hazards associated with participating in the Educational Experience in a health care setting, particularly in circumstances where I am permitted in high-risk patient care areas. Further, I understand that in spite of appropriate precautions, there are risks of infections and contradicting communicable diseases. Also if I do not use proper care and follow directions given to me, I may injure others or myself or cause damage to my property or the property of others. By participating in the Educational Experience, I agree to assume such risks, including the added risks associated with high-risk patient care areas. I agree to accept responsibility for my own actions and not to hold Provider responsible for such actions. I will not seek damages or other compensation from Provider for any injuries to me or my property, unless such injuries are caused by the gross negligence or willful misconduct of the Provider, its employees or agents, nor will I ask the Provider to pay for any injuries that I might cause to others or the property of others, including Provider's property, except to the extent that such injuries are not covered by my insurance, but are covered by the Provider's insurance.

Binding Agreement: I acknowledge that I have read this Agreement and that I understand and agree that any violation of this agreement may involve violations of state and federal laws and regulations governing the patient's right to privacy or the right of a company to maintain the confidentiality of its business records. I recognize that the disclosure of information by me may give rise to irreparable injury to you or your patients and that you or your patients may seek any legal remedies against me that may be available in the event of such disclosure.

Signature	Last 4 of SSN	Date (MM/DD/YY)	Print Your Full Name

Rev 02152013

Print Form