WVU Medicine
WVU Hospitals/University Health Associates

Job Shadowing Authorization/Release of Liability

I certify that all information contained in this request for job shadowing is true to the best of my knowledge and belief. I agree that any misleading or false statements would render this request void and would be sufficient cause for immediate disapproval of my request or subsequent removal from the Job Shadowing Program.

I certify that I have reviewed the Job Shadow Program Overview and agree to abide by all standards and expectations contained in the overview.

If accepted into the Job Shadowing Program, I shall and do hereby agree to indemnify and save WVU Hospitals / University Health Associates, its directors, officers, employees, agents, servants, successors, and assigns harmless from any and all claims, demands, causes of action, liability damages, or loss, including reasonable attorneys fees and defense costs, which WVU Hospitals / University Health Associates may at any time sustain or incur by reason of any act or omission to act arising out of or related to my participation in the Job Shadowing Program.

_____
Participant's Printed Name

_____ _____
Participant's Signature Date

If under 18 years of age, notarized signature of parent or legal guardian is required.

_____
Parent/Legal Guardian's Printed Name

_____ _____
Parent/Legal Guardian's Signature Date

STATE OF _____ COUNTY OF _____, ss.:

On this day, personally appeared before me
_____,
to me known to be the person(s) described in and who executed the within and foregoing instrument, and acknowledged that he/she signed the same as his/her voluntary act and deed, for the uses and purposes therein mentioned.

Witness my hand and official seal hereto affixed

this _____ day of _____, _____.

_____

Notary Public in and for the State of _____

My commission expires _____.