WAIVER AND RELEASE OF LIABILITY

1. The undersigned seeks to ride along as a guest in a vehicle or aircraft owned and operated by The Charlotte-Mecklenburg Hospital Authority d/b/a Atrium Health ("Atrium Health").

2. I understand that as a ride along participant I will be exposed to the particular risks and dangers to which a passenger of a vehicle or aircraft is commonly exposed. I fully understand Atrium Health will not be held liable for any accident, incident, injury, illness, and/or any other undesirable occurrence that I could potentially encounter and/or endure during my experience. I agree to indemnify and hold harmless Atrium Health against any and all claims, suits or actions of any kind whatsoever for liability, damages, compensation or otherwise brought by me or anyone on my behalf, including attorney fees, if litigation arises on account of claims made by me or anyone on my behalf.

3. I attest that I am covered by (i) commercial general liability insurance, which includes coverage for personal liability, bodily injury (including death) with respect to my occupancy of an Atrium Health vehicle; and (ii) worker's compensation and employer's liability insurance in amounts adequate to comply with applicable law. Upon request by Atrium Health, the undersigned will provide a certificate of insurance to Releasee confirming such coverage.

4. I agree to comply with all Atrium Health policies and procedures, including any and all infectious disease prevention measures and confidentiality requirements, while on Atrium Health property and participating in Atrium Health's services. Atrium Health will make available any applicable policies upon your request.

5. As a part of my ride along experience, I understand that I may be involved in direct patient contact and/or have access to privileged patient information during my scheduled observational experience. I understand that I am obligated by law to protect the privacy and confidentiality of any and all patients that I may encounter by keeping all patient information in strict confidence at all times. I understand these expectations and agree to adhere to them as they are outlined by State and Federal HIPAA guidelines as well as the Atrium Health Confidentiality Policy (PR 140.02, Confidentiality of Patient/Teammate Information).

I hereby declare that I have read and fully understand this Release and Waiver in its entirety and that by signing below, I agree to all of the terms and conditions noted above.

_____ _____

Signature Date

_____ _____

Employer Title

Name:

Company:

Street Address 1:

City/Town:

State:

Zip:

Email Address:

Phone Number:

Date of Birth:

Current Weight:

Credential Level:

Emergency Contact Information

Name:

Address:

City/Town:

State:

Zip:

Email Address:

Phone:

Medical Information

Medical History:

Allergies:

MD Name:

MD Phone:

Dentist Name:

Dentist Phone: