

UW-L Health Professions Department
Medical Dosimetry Program
STUDENT'S RELEASE OF LIABILITY

This form must be submitted prior to participation in any program classes

I, (print name) _____ have been accepted as a graduate student in the Department of Health Professions at the University of Wisconsin-La Crosse. I understand that I will examine and be examined by faculty and students in the program to practice techniques and learn various procedures. I hereby release the University, its agents and employees and agree to hold it and them harmless from any and all liability, claims, damages, actions, and causes of actions whatsoever, for loss, damages or injury to persons or property, irrespective of how arising and however caused, including but not limited to all kinds and degrees or extent of negligence with which the University, its agents or employees may be charged in connection, directly or indirectly, with these instructions.

I further agree to disclose, in writing, any physical and medical conditions, limitations or sensitivities that may require special accommodations, and agree to release and hold the University, its agents and employees harmless from any liability, claims, damages, actions, and causes of action in any way relating to or arising from said conditions, limitations and sensitivities. I expressly agree that all instruction and use of all facilities and equipment shall be undertaken at my own risk, and I represent that I am physically and medically able to undertake any and all instructions provided.

I further agree that the University of Wisconsin-La Crosse Health Professions Department, its agents and employees shall not be liable for any claims, demands, injuries, damages, actions, or causes of action whatsoever arising out of, or connected with the use of any of its services, facilities or equipment. I hereby expressly forever release and discharge the University, its agents and employees from all such claims, demands, injuries, damages, or actions or causes of action, and from all acts of active and passive negligence on the part of the University of Wisconsin-La Crosse Health Profession Programs, its agents or employees.

***** **INTERNSHIP WAIVER** *****

I understand that clinical learning experiences are an essential part of the professional education of the Health Professions Department. Clinical learning environments are becoming an increasingly scarce resource creating challenges for convenient placement of students due to a number of factors including increased number of programs emerging within academic institutions, changes within the health care environment forcing some sites to reconsider the number of students because of issues related to reimbursement, litigation, and staff productivity associated with placements. All of these factors as well as others have resulted in fewer learning spaces being offered for students. I understand that if I agree to enter the Health Profession programs based upon the quality of the learning experience and the clinical learning will be made based upon the quality of the learning experience and the clinical site resources available. This most likely will necessitate placement in sites that may be inconvenient geographically of have additional expenses associated with them. Personal concerns regarding weddings, family issues, vacations, or future employment issues will not be a consideration. As a student entering the UW-L Health Profession Program, I understand and agree to accept responsibility for the expenses and inconvenience that may occur as a result of clinical assignments, which are requirement of my professional training.

***** **RELEASE OF EXAM SCORE** *****

I understand that my MDCB exam score will be released to the program upon completion of the exam. This will assist with program accreditation requirements as well as provide assessment information to the program director for future improvements to curriculum and instruction.

Criminal Background Authorization

*******AUTHORIZATION, ACKNOWLEDGEMENT, AND RELEASE FORM*******

I hereby authorize the University of Wisconsin-La Crosse (UW-L), Health Professions Department to obtain criminal records about me from any source. I also authorize UW-L Health Professions Department to provide such records to third parties for the purposes of evaluating my application for acceptance into or continued participation in an internship or field/clinical placement/rotation.

In the event I am accepted into an internship or field/clinical placement/rotation, I hereby acknowledge that during the course of my internship or field/clinical placement I shall notify UW-L Health Professions Department as soon as possible, but no later than the next day I am expected to attend the internship or field/clinical placement, when I have been convicted of any crime or have been or are being investigated by any governmental agency for any act or offense. I further acknowledge that if I fail to abide by this acknowledgement, UW-L Health Professions Department has the right to immediately terminate my participation in an internship or field/clinical placement.

I hereby release such third parties and the Board of Regents of the University of Wisconsin System, its agents, employees, and officers, including the University of Wisconsin-La Crosse Health Professions Department from any liability that may arise from the disclosure of any information contemplated by this form or from UW-L Health Professions Department terminating me from an internship or field/clinical placement as described in the immediately preceding paragraph.

I understand that this form is in effect until my degree is completed at UW-L, unless I revoke it in writing and provide such revocation to the Program Director or Chair of the Department/Program at the Health Professions Department, 4th floor of the Health Science Center. I further understand that if I choose to revoke this form, I may not be able to participate in an internship or field/clinical placement/rotation. I have read and understand the above authorization, acknowledgement and release.

Video and Photo Release

As a student within the Health Professions Department at UW-La Crosse, I am aware that photographs and videotaped clips of classroom, laboratory, volunteer, and clinical activities may occur that would involve pictures and videotape clips of me as a participant in these educational activities.

I agree to the use of any pictures and videotaped segments for future program needs – including educational and marketing needs of the program or university.

*******Your signature and date at the bottom of this form verifies you have understood and agree with the Student Release of Liability form, Internship Waiver form, Release of Exam Score, Criminal Background Authorization form and Video & Photo Release form.**

Date: _____

Signature: _____