

## INSTRUCTIONS FOR USE OF SCHEDULE B WAIVER TEMPLATE:

1. This waiver is only required when STUDENTS or visiting INSTITUTION STAFF must secure their own medical and/or accident insurance because they don't have WorkSafe BC or an equivalent coverage (e.g., workers compensation coverage from another province) during the practice education placement.
2. Please replace [HA] with the name of the participating Health Authority.
3. Select the appropriate signature block depending on if the waiver is being used for a STUDENT or visiting INSTITUTION STAFF (i.e., when the waiver is used for a STUDENT, delete the signature block for the visiting INSTITUTION STAFF).
4. **The INSTITUTION is not required to sign this waiver.** Only when the waiver is being used for visiting INSTITUTION STAFF, will the visiting INSTITUTION STAFF sign on their own behalf.

# Waiver of Legal Rights

(For STUDENTS or visiting INSTITUTION STAFF who are Responsible for Arranging Their Own Medical/Accident Insurance)

**THIS DOCUMENT AFFECTS YOUR LEGAL RIGHTS, INCLUDING YOUR RIGHT TO SUE. PLEASE READ CAREFULLY. YOU MAY WISH TO SEEK INDEPENDENT LEGAL ADVICE IN RESPECT OF THIS AGREEMENT.**

1. I understand there can be significant dangers, including the risk of acquiring a serious illness, sustaining a psychological or physical injury, or death, associated with working in a clinical health care setting or hospital during a Practice Education experience.
2. I acknowledge and accept these risks and all other risks associated with participating in this Practice Education experience.
3. I accept full responsibility and release [HA] from all liability for any loss, injury or damage that I may suffer arising from or related to my participation in the Practice Education experience, including any physical or psychological injury arising from exposure to health risks. I release and discharge [HA], its directors, officers, employees, volunteers, agents, contractors and attending physicians from any and all liability for any loss, injury or damage which I may suffer during the Practice Education experience.
4. I waive any right of recovery from [HA], its directors, officers, employees, volunteers, agents, contractors and attending physicians, that I may otherwise be entitled to at law. I acknowledge and accept that [HA] disclaims all liability for such risks.
5. I acknowledge that *Workers' Compensation*, accident, or similar death & disability coverage is not available to me from [HA] or Institution during the Practice Education. I have been advised by the Institution of my responsibility to obtain medical and/or accident insurance coverage myself.
6. I agree that this Agreement is governed by the laws of British Columbia, and any applicable laws of Canada, where I am participating in the Practice Education. I irrevocably submit to the exclusive jurisdiction of the courts of British Columbia.
7. I have read and understand this document and I am aware that by signing this waiver I may surrender certain legal rights.
8. I \_\_\_\_\_ (insert name of STUDENT or visiting INSTITUTION STAFF), confirm that I have read, understood, and accepted the terms of this Agreement as evidenced by my signature below.
9. I agree I have been given time to seek independent legally advice and sign this document voluntarily.

IF YOU HAVE ANY QUESTIONS REGARDING ANY OF THE CONTENTS OF THIS DOCUMENT, PLEASE CONTACT US PRIOR TO SIGNING IT.

**[Select appropriate signature block: STUDENT or INSTITUTION STAFF]**

## I am 19 years of age or older:

\_\_\_\_\_  
Signature of STUDENT

\_\_\_\_\_  
Print name of STUDENT

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of visiting INSTITUTION STAFF

\_\_\_\_\_  
Print name of visiting INSTITUTION STAFF

\_\_\_\_\_  
Date

## I am under 19 years of age:

\_\_\_\_\_  
Signature of STUDENT

\_\_\_\_\_  
Print name of STUDENT (the "Minor")

\_\_\_\_\_  
Date

## **PARENT OR GUARDIAN (required where Participant is under 19 years of Age):**

I am the Minor's parent and/or legal guardian I understand there can be significant dangers, including the risk of acquiring a serious illness, sustaining a psychological or physical injury, or death, associated with working in a clinical health care setting or hospital during a Practice Education experience. I acknowledge and accept these risks and all other risks associated with my child/charge participating in this Practice Education experience. I release and discharge [HA], its directors, officers, employees, volunteers, agents, contractors and attending physicians from any and all liability for any loss, injury or damage, which my child/charge may suffer during the Practice Education experience. I waive any right of recovery from [HA], its directors, officers, employees, volunteers, agents, contractors and attending physicians that I may otherwise be entitled to by law. I acknowledge and accept that [HA] disclaims all liability for such risks.

\_\_\_\_\_  
Signature of PARENT/ LEGAL GUARDIAN

\_\_\_\_\_  
Print name of PARENT/ LEGAL GUARDIAN

\_\_\_\_\_  
Date