

Important advisories:

- Job shadow participants must be at least 15 years old.
- Job shadow experiences generally last 2-6 hours and no more than 12 hours. If you need more than 12 hours on-site experience, consult the practice manager.
- Participants should wear closed-toe shoes and long pants during their job shadow experience. Wear clothes you won't mind getting dirty. We can provide a scrub top for you.

WAIVER AND RELEASE OF LIABILITY

I, _____, agree to participate in a job shadowing experience provided by the Animal Hospital of Pasco, P.S.

Job shadowing work experience is a temporary, unpaid exposure to the veterinary workplace and is entirely voluntary. I hereby acknowledge that by attending and participating in the job shadowing experience that I am fully aware of the possibility of physical illness or serious/fatal injury, including, but not limited to, exposure to pathogens and other potentially infectious materials and animal bites, and I knowingly assume any and all risks associated with the job shadowing experience. I do hereby for myself, my personal representatives, heirs, assigns, and all others who might have a similar claim, waive, release and forever discharge any and all rights, claims and liabilities for injury whether from exposure during the job shadowing experience or otherwise and whether foreseen or unforeseen, known or unknown, which may arise now or in the future against Animal Hospital of Pasco, P.S. and its owners, administrators, officers, agents or representatives, for any and all damages which I may sustain or suffer while attending and participating in the job shadowing experience. I agree not to sue Animal Hospital of Pasco, P.S. for any of the claims and liabilities that I have waived, released or discharged herein; and I indemnify and hold harmless Animal Hospital of Pasco, P.S. from any claims made or liabilities assessed against them as a result of my actions. I understand that this release, waiver and agreement to indemnify and hold harmless includes, but is not limited to, damages which are caused, or alleged to be caused, in whole or in part by the negligence of Animal Hospital of Pasco, P.S.

I have provided to Animal Hospital of Pasco, P.S. proof of medical insurance covering myself for any injury that may occur during the job shadowing experience and fully understand that I am solely responsible for any and all medical expenses that are not covered or paid for by my medical insurer.

I agree to keep confidential and not disclose to any person any confidential information that I learn in connection with the job shadowing experience and, if I am unclear about what constitutes confidential information, to ask the person at Animal Hospital of Pasco, P.S. who is supervising my job shadowing experience. I understand that any property of Animal Hospital of Pasco, P.S. that I receive and all records and papers of any kind relating to Animal Hospital of Pasco, P.S. shall be the exclusive property of Animal Hospital of Pasco, P.S.

Without the prior written consent of an authorized officer of Animal Hospital of Pasco, P.S., I shall not duplicate or disclose to any third party any confidential or proprietary information or trade secret pertaining to the business, products or services of Animal Hospital of Pasco, P.S.

By signing this Waiver and Release of Liability I consent to the use of my name and/or photograph or other likeness by Animal Hospital of Pasco, P.S. without any additional compensation or inspection. I also confirm that I am over the age of 18 or if I am under the age of 18, my parent or legal guardian has signed on my behalf, and that all facts in this Waiver and Release of Liability are true.

I further state that I have carefully read the foregoing Waiver and Release of Liability, know the contents thereof, understand that by signing it I have given up substantial rights, and agree to sign this Waiver and Release of Liability as my own free act and deed.

Signature of participant

Date (mm/dd/yy)

Signature of parent or legal guardian
(if participant is under 18 years of age)

Date (mm/dd/yy)

Participant phone number

ATTACHED DOCUMENTS:

Photocopy of participant's ID

(if you don't have a state-issued ID, a school ID is fine)

Proof of medical insurance for participant

This release (and associated documents) must be returned to the practice manager. Once these documents have been accepted, the practice manager will call you at the number you've provided above.

Henry James, Practice Manager
henry.james@pascovets.com
Direct voicemail: (509) 416-6140

Roberta Quick, LVT, Lead Technician

Primary office telephone: **(509) 545-9949**

IN CASE OF MEDICAL EMERGENCY:

If the participant has any severe allergies (including allergies to medications) or chronic medical conditions (epilepsy, for example) please list them here:

First emergency contact name: _____ Phone: _____

Second emergency contact name: _____ Phone: _____

Third emergency contact name: _____ Phone: _____