

STUDENT CLINICAL LEARNING EXPERIENCE AGREEMENT

In consideration for participating in an clinical learning experience (hereinafter referred to as the "C.L.E.") at any Practice where I may participate in such an C.L.E. (hereinafter referred to as the "Practice"), I hereby agree to the following:

1. To follow the administrative policies, standards and practices of the Practice when in the Practice.
2. To report to the Practice on time and to follow all established regulations of the Practice.
3. To keep in confidence all medical, health, financial and social information (including mental health) pertaining to particular clients or patients.
4. To not publish any material related to my C.L.E. that identifies or uses the name of the MP, the Board of Regents of the University System of Georgia, the Practice or its members, clients, students, faculty or staff, directly or indirectly, unless I have received written permission from the MP, the Board of Regents of the University System of Georgia, and the Practice. However, the Practice hereby grants to the MP the right to publish MP administrative materials such as catalogs, course syllabi, C.L.E. reports, etc. that identify or uses the name of the Practice or its members, staff, directly or indirectly.
5. To comply with all federal, state and local laws regarding the use, possession, manufacture or distribution of alcohol and controlled substances.
6. To follow Center for Disease Control and Prevention (C.D.C.) Universal Precautions for Bloodborne Pathogens, C.D.C. Guidelines for Tuberculosis Infection Control, and Occupational Safety and Health Administration (O.S.H.A.) Respiratory Protection Standard.
7. To arrange for and be solely responsible for my living accommodations while at the Practice.
8. To provide the necessary and appropriate uniforms and supplies required where not provided by the Practice.
9. To wear a name tag that clearly identifies me as a student.

Further, I understand and agree, unless otherwise agreed to in writing, that I will not receive any monetary compensation from the Board of Regents of the University System of Georgia, the MP or the Practice for any services I provide to the Practice or its clients, students, faculty or staff as a part of my C.L.E.

Unless otherwise agreed upon in writing, I also understand and agree that I shall not be deemed to be employed by or an agent or a servant of the MP, the Regents or the Practice; that the MP, Regents and Practice assumes no responsibilities as to me as may be imposed upon an employer under any law, regulation or ordinance; that I am not entitled to any benefits available to employees; and, therefore, I agree not to in any way to hold myself out as an employee of the MP, the Regents or the Practice.

I understand and agree that I may be immediately withdrawn from the C.L.E. based upon a lack of competency on my part, my failure to comply with the rules and policies of the MP or Practice, if I pose a direct threat to the health or safety of others or, for any other reason the MP or the Practice reasonably believes that it is not in the best interest of the MP, the Practice or the Practice's patients or clients for me to continue. Such party shall provide the other party and the student with immediate notice of the withdrawal and written reasons for the withdrawal.

I understand and agree to show proof of professional liability insurance in amounts requested by the Practice and covering my activities at the Practice, and to provide evidence of such insurance upon request of the Practice.

I further understand that all medical or health care (emergency or otherwise) that I receive at the Practice will be my sole responsibility and expense.

I have read, or have had read to me, the above statements, and understand them as they apply to me. I hereby certify that I am eighteen (18) years of age or older, or my parent or guardian has signed below; that I am legally competent to execute this Clinical Learning Agreement; and that I, or my parent and/or guardian, have read carefully and understand the above Clinical Learning Experience Agreement; and that I have freely and voluntarily signed this "Clinical Learning Experience Agreement".

This the _____ day of _____, 201_.

Participant Signature

Witness Signature

Participant Name (Please Print)

Witness Name (Please Print)

Parent / Guardian Signature (if applicable)

Witness Signature

Parent / Guardian Name (Print if applicable)

Witness Name (Please Print)