DEPARTMENT OF MEDICAL EDUCATION
NICKLAUS CHILDREN'S HOSPITAL
SHADOW AGREEMENT AND RELEASE

I, Mr. /Ms. _____ of _____ City/State _____Country _____in consideration of being allowed to participate in physician shadowing at Nicklaus Children's Hospital ("NCH") do hereby agree that:

1. I understand and agree that my shadowing will be for a period of _____ from _____ mm/dd/yyyy) to _____ (mm/dd/yyyy), and that it shall consist of observing the activities of (attending/division) _____ at NCH. At the end of such period, I understand that my shadowing experience will cease and I will no longer be permitted access to NCH facilities.

2. I understand that NCH will not be providing liability. I will not be involved in any patient contact activities or be present with patients without supervision. These shadowing activities will not constitute clinical training.

3. I understand that my experiences for observation **ONLY**. I will not be permitted to actively participate in patient care or contact, examination, research or other work during the time at NCH. I understand and agree that my shadowing experience is in no way an offer of or employment by NCH and that I shall not receive, nor be entitled to receive, any compensation, reimbursement or remuneration for my participation in my shadowing. I further understand and agree that at no time will I be considered or deemed to be an agent, servant or employee of NCH, I further agree to release NCH from any and all claims to compensation, reimbursement or remuneration related to my shadowing experience.

4. I agree that I will provide NCH with proof of valid legal status from the appropriate authorities for the term of my shadowing and I agree to maintain and comply with all the requirements of such status for the duration of the shadowing.

5. I understand that I will be observing the activities at NCH and I therefore agree to act appropriately and in a professional, courteous manner during my shadowing experience. I understand and agree that my shadowing experience may be terminated by NCH at any time, with or without cause.

6. I understand that I will ALWAYS be supervised by the preceptor I am shadowing (whose signature appears on this agreement) or his/her designee(s). If at any point in time I violate the terms of this agreement and deviates from the scope of this agreement, I understand that it is the duty of my preceptor/supervisor to report this violation to the Medical Education Department and I understand that my showing experience will be terminated and this violation can potentially be reported to any entity/ school for which this shadowing is performed.

7. In the event my shadowing experience involves observing direct patient care, I understand that such patients are entitled to confidentiality and I hereby agree not to disclose, discuss or reveal any details about such patients to anyone other than those involved in my shadowing with me.

Nicklaus Children's Hospital
MIAMI CHILDREN'S HEALTH SYSTEM

8. I acknowledge that I am responsible for all of my medical expenses (including repatriation, should that become necessary) in the event I become ill or injured in the United States during my shadowing experience. I understand that NCH neither provides medical insurance nor covers expenses incurred for medical treatment during the period of shadowing.

9. I understand that I will complete all required paperwork as listed on the Requirement Checklist and orientation prior to the first day of my shadowing. I understand that I will be required to provide proof that I have been tested for tuberculosis and have had the mandatory immunizations as required by NCH. I will arrive at the NCH department of Medical Education, the first day of my shadowing, to receive my NCH ID badge.

10. In consideration of my being allowed to participate in as a shadow, I agree to indemnify MCH, its affiliates and their respective officers, directors, employees and agents, against and hold the same harmless from any and all claims, losses, damages, liabilities, actions, judgments, costs and expenses (including settlements, judgments, court costs and reasonable attorneys' fees and costs) of any nature or kind whatsoever, which I may have or accrue as a result of or arising out of my participation in the shadowing experience, including airborne pathogens, whether caused by the negligence, action or inaction of NCH or otherwise. I also agree that I shall be fully responsible for any and all loss or damage that I inflict upon any person or upon NCH's facilities during my participation in the shadow program. I understand that this release is intended to be as broad and inclusive as is permitted by the laws of the State of Florida.

11. Have you ever been convicted of a criminal offence, charged with an offence, or are you at present, the subject of criminal charges? (Circle one) YES / NO

If "yes" please provide the following details (answering "yes" to this question will not lead to automatic disqualification; however, failure to provide relevant information will lead to disqualification and/or termination of the Observership Program).

- Date(s) of conviction(s)/charge (s):
  _____
- Outcome of conviction(s)/charge(s):
  _____
- Please provide relevant details of the nature of the conviction(s)/charge(s):

  _____

  _____

IN WITNESS WHEREOF, the undersigned has signed this Shadow Agreement on the ___ day of _____, 20___ as an attestation to comply with all the terms of this agreement stated above.

_____

Participant (print name)

Nicklaus Children's Hospital
MIAMI CHILDREN'S HEALTH SYSTEM

_____

Participant (sign name)

PRECEPTOR/ SUPERVISOR ATTESTATION

IN WITNESS WHEREOF, the undersigned has signed this Shadow Agreement on the ___ day of _____, 20___ as an attestation to comply with all the terms of this agreement stated above and to abide by the terms related to the preceptor/supervisor role.

_____

Preceptor (print name)

_____

Preceptor (sign name)

DEPARTMENT OF MEDICAL EDUCATION

_____

Governing Department Medical Education Office Designated Official (sign name) & Date