UNIVERSITY of MARYLAND
REHABILITATION &
ORTHOPAEDIC INSTITUTE

HEALTHCARE SHADOW DAY INFORMATION FORM

Name of Provider you are shadowing: _____

Name: _____

E-mail: _____

Signature: _____ **Date:** _____

If under 18, Signature of parent/guardian: _____ **Date:** _____

RELEASE OF LIABILITY

In consideration of participation in the Therapy Shadow Program at UM Rehab & Ortho I agree for myself and behalf of all my heirs and beneficiaries to release UM Rehab & Ortho I and all its agents, employees, co-sponsors, and insurance carriers from any and all liability, claims, demands, or any causes of action. I agree not to sue or otherwise make any claim against UM Rehab & Ortho and its agents, employees, co-sponsors and insurance carriers whatsoever which may arise as a result of my participation in the Shadow Program at UM Rehab & Ortho. I assume full responsibility for any risk occurring from my participation. I agree to indemnify and hold harmless UM Rehab & Ortho and its agents, employees, co-sponsors and insurance carriers from all claims, judgments, expenses and cost, including but not limited to attorney's fees, incurred in connection with any claims/lawsuits or other legal action brought as a result of my participation in the Shadow Program at UM Rehab & Ortho.

_____ _____
Signature of Participant Date

CONFIDENTIALITY

I understand that all medical and personal information regarding patients of UM Rehab & Ortho is confidential and, unless directly related to the care of patients, should not be revealed or discussed with other patients, friends or relatives, or anyone else within or outside of University Providers. I also understand that other information regarding the operation of UM Rehab & Ortho confidential. This confidential information concerns, but is not limited to, employees, financial operations, quality assurance, utilization review, risk management, research, contracting, procurement and credentialing of staff. I understand that I am only authorized to access this information if it is required for me to perform my duties. This information should not be discussed with others within or outside of University Providers except to the extent that this discussion is necessary to perform my duties.

_____ _____
Signature of Participant Date

DRESS CODE ACKNOWLEDGEMENT

I acknowledge that as a Shadow Program participant at UM Rehab & Ortho I must wear a Visitors Badge (obtain from main entrance receptionist desk) at all times while in the hospital (does not apply to offsite.) I acknowledge that I must follow the hospital's dress code and my clothing should be neat, clean, loose fitting, and in good repair. I acknowledge UM Rehab & Ortho has a no denim (jeans) policy. I am to wear slacks, shirts (preferably collared,) flat closed-toed shoes and a minimal amount of jewelry if any (no long earrings).

_____ _____
Signature of Participant Date

Please return this form to the Volunteer Office prior to your shadow day.