COMMUNICABLE DISEASE ACKNOWLEDGEMENT OF RISK AND RELEASE OF LIABILITY

In accordance with Chesapeake Regional Healthcare (CRH) sick policy, employees and affiliates are unable to report to work sick with potential signs or symptoms of contagious diseases, such as flu, pink eye, COVID-19, chicken pox, mumps, measles, shingles, Tb, hepatitis, meningitis, salmonella, etc. Symptoms to include, but not limited to fever >100.0, chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea/vomiting, unexplained rash/lesions, swollen lymph nodes, with any of the above symptoms and/or pink or red coloring of the eyes with discharge (pus or mucus) or crusting of eyelids or lashes, especially in the morning.

1. You will comply with all applicable CRH policies and procedures, including the time and attendance policy and sick and return to work guidelines.
2. You agree and have or will provide verification (October through April), that you have or will receive the influenza vaccination and/or religious/medical exemption. If unvaccinated, you will be required to mask at all times, even in non-patient care areas, during all meetings and where other healthcare professionals are present.
3. If you exhibit any of the symptoms as outlined above, you agree to follow CRH sick policy and will not report to your scheduled assignment until you have been cleared by your personal physician and/or tested and ruled out of COVID-19, influenza, or other communicable diseases.
4. Participants of SCOPE will not be allowed to observe surgical cases where N95 respiratory protection is required.
5. If you have tested positive for COVID-19 and influenza, you are unable to return to CRH for at least 5 days from date of symptom on-set, if your symptoms are resolving. Upon return you acknowledge and agree to follow enhanced precautions for an additional 5 days to include:
   - Surgical Mask at all times when interacting with other health care professionals and visitors, even when you are in non-patient care areas such as breakrooms, cafeteria, personal workstations, meetings, etc.
   - SCOPE observers will not be allowed to interact with patients for an additional five days and will follow current PPE guidelines regardless of vaccination status.

Current PPE and Precaution Guidelines to always follow. . .

- Practice physical distancing from coworkers at all times.
- Proper hand hygiene and cleaning/disinfecting of work area and frequently touched surfaces.
- Self-monitor for symptoms and seek re-evaluation from occupational health if symptoms appear.

By signing this acknowledgement and release, you, on your behalf and the behalf of your heirs, assigns, and personal representatives, voluntarily agree to assume all of the foregoing risks and accept sole responsibility for any injury/illness to you, including without limitation, illness, disability, death, damages, loss, claim, liability, or expense ("claims"), of any kind, that you may experience or incur in connection with your participation in the SCOPE program. You forever release, covenant not to sue, discharge, and hold harmless CRH, its employees, agents, and representatives, of and from the claims, including all liabilities, damages, expenses, claims, demands, actions, and causes of action whatsoever arising out of related to any loss, injuries, including death, that may be sustained by you as a result of your participation in the SCOPE program. Acknowledged and agreed to by:

Name (Print): _____ Signature: _____ Date: _____

If under the age of 18 parental/guardian signature is required.

Parent/Guardian Name (Print): _____ Signature: _____ Date: _____

SCOPE | STUDENT CLINICAL OBSERVATION AND PROFESSIONAL EXPLORATION

RELEASE AND WAIVER FROM LIABILITY

I voluntarily release Chesapeake Regional Healthcare, its successors, assigns, affiliates, subsidiaries, directors, officers, agents, and team members from all liability for any claim or cause of action, I, my heirs, or assigns, might now or hereafter have for injury, loss, damage, or death rising out of, or incident to my SCOPE participation. I agree to hold Chesapeake Regional Healthcare harmless from all claims, losses, liability, and demands that realized due to my negligence, gross negligence, willful misconduct, or violation of this Agreement. I understand that the Privilege of being allowed to observe depends on my executing and complying with the Agreement. I understand that this privilege may be revoked or modified at any time without cause or prior notice at the entity's sole discretion. I have read and understand this agreement as well as the Release and Waiver from Liability.

OBSERVER MUST COMPLETE AND SIGN BELOW

I hereby consent to follow all guidelines outlined in the provided SCOPE training materials. I realize I must act responsibly and professionally in this role, and I also understand that I am to function as an observer only and am not permitted to act in any role other than that of an observer.

SCOPE OBSERVER NAME PRINTED: _____

SCOPE OBSERVER SIGNATURE: _____ **DATE:** _____

WITNESS PRINTED NAME: _____ **WITNESS PHONE #:** _____

WITNESS ADDRESS: _____
Street City State Zip Code

WITNESS SIGNATURE: _____ **DATE:** _____

IF OBSERVER IS UNDER 18 YEARS OF AGE, PARENT/GUARDIAN MUST COMPLETE AND SIGN BELOW

PARENT/GUARDIAN NAME PRINTED: _____

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

WITNESS PRINTED NAME: _____ **WITNESS PHONE #:** _____

WITNESS ADDRESS: _____
Street City State Zip Code

WITNESS SIGNATURE: _____ **DATE:** _____