UNIVERSITY OF
SOUTH CAROLINA
College of Nursing

AUTHORIZATION FOR RELEASE OF RECORDS AND INFORMATION

Re: _____
(Print Name of Student)

To: The University of South Carolina (hereinafter referred to as the "UNIVERSITY"), and any facility where I participate in or request to participate in an applied learning experience (hereinafter referred to as the "FACILITY").

As a condition of my participation in an applied learning experience and with respect thereto, I grant my permission and authorize the UNIVERSITY or any of its member institutions to release my educational records and information in its possession, as deemed appropriate and necessary by the UNIVERSITY, including but not limited to academic record and health information to any facility where I participate in or request to participate in an applied learning experience, including but not limited to the FACILITY. I further authorize the release of any information relative to my health to the FACILITY for purposes of verifying the information provided by me and determining my ability to perform my assignments in the applied learning experience. I also grant my permission to and authorize the FACILITY to release the above information to the UNIVERISTY. The purpose of this release and disclosure is to allow the FACILITY and the UNIVERSITY to exchange information about my medical history and about my performance in an applied learning experience.

I further understand that I may revoke this authorization at any time by providing written notice to the above stated person(s)/entities, except to the extent of any action(s) that has already been taken in accordance with this "Authorization for Release of Confidential Records and Information."

I further agree that this authorization will be valid throughout my participation in the applied learning experience. I further request that you do not disclose any information to any other person or entity without prior written authority from me to do so, unless disclosure is authorized or required by law. I understand that this authorization shall continue in force until revoked by me by providing written notice to the UNIVERSITY and the FACILITY, except to the extent of any action(s) that has already been taken in accordance with this "Authorization for Release of Records and Information".

In order to protect my privacy rights and interests, other than those specifically released above, I may elect not to have a witness to my signature below. However, if there is no witness to my signature below, I hereby waive and forfeit any right I might have to contest this release on the basis that there is no witness to my signature below. Further, a copy or facsimile of this "Authorization for Release of Records and Information" may be accepted in lieu of the original.

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; that I am legally competent to execute this "Authorization for Release of Records and Information"; and that I have freely and voluntarily signed this "Authorization for Release of Records and Information."

This _____ day of _____, _____.

Participant Name: _____
(Please print)

Signature: _____

Witness Name: _____
(Please print)

Signature: _____

UNIVERSITY OF
SOUTH CAROLINA
College of Nursing

PARTICIPANT CLINICAL EDUCATION EXPERIENCE AGREEMENT

In consideration of my participation in a clinical education experience program at the FACILITY or any other facility where I may participate in such a program (hereinafter referred to as the "FACILITY"), I agree:

1. To follow the policies, standards and practices of the FACILITY when in the FACILITY, including HIPAA.
2. To abide by the UNIVERSITY's policies, including applicable Code of Conduct and honor codes.
3. To report to the FACILITY on time and to follow all established regulations of the FACILITY.
4. If requested, to undergo a health examination as necessary to meet program requirements, including testing to determine infectious or contagious diseases. Also, to provide evidence of immunity, as may be appropriate and to meet program requirements.
5. To keep in confidential and private all medical, health, mental health, financial and social information pertaining to any particular client or patient.
6. Not to publish any material related to the clinical education experience that identifies or uses the name of the UNIVERSITY and the FACILITY, its members, officers, clients, patients, students, or faculty, directly or indirectly, unless I have first received written permission from the UNIVERSITY and the FACILITY.
7. To comply with all federal, state and local laws regarding the use, possession, manufacture or distribution of alcohol and controlled substances.
8. To follow Center for Disease Control and Prevention (C.D.C.) Universal Precautions for Bloodborne Pathogens, C.D.C./DHEC Guidelines for Tuberculosis Infection Control, and Occupational Safety and Health Administration (O.S.H.A.) Respiratory Protection Standards.
9. To arrange for and be solely responsible for my living accommodations while at the FACILITY. as may be applicable.
10. To provide the necessary and appropriate uniforms and supplies required where not provided by the FACILITY.
11. To wear a nametag that clearly identifies me as a student at all times while in the FACILITY.
12. Not to hold myself out as an employee of the UNIVERSITY or the FACILITY unless explicitly authorized.

Further, I understand and agree that I will not receive nor accept monetary compensation from the UNIVERSITY or the FACILITY.

I also understand and agree that I shall not be deemed to be employed by or an agent or a servant of the UNIVERSITY or the FACILITY; that the UNIVERSITY and FACILITY assume no responsibilities for me as may be imposed upon an employer under any law, regulation or ordinance; and that I am not entitled to any benefits available to employees.

I understand and agree that I may be immediately withdrawn from the FACILITY's educational training program or dismissed, suspended or expelled based upon a perceived lack of competency on my part, my failure to comply with the rules and policies of the UNIVERSITY or FACILITY, if I pose a direct threat to the health or safety of others or, for any other reason the UNIVERSITY or the FACILITY reasonably believes that it is not in the best interest of the UNIVERSITY, the FACILITY or the FACILITY' s patients or clients.

I acknowledge that no clinical health requirement item may expire prior to the last day of classes in the semester in which I am enrolled. Failure to submit health information by deadlines will result in the non-release of registration holds.

I further understand that potential risks of clinical education include, but are not limited to, exposure to infectious diseases, hazardous chemicals and musculoskeletal disorders including back injuries.

If required by my Graduate Program, I understand and agree to show proof of liability insurance in amounts satisfactory to the FACILITY, and covering my activities at the FACILITY, and to provide evidence of such insurance upon request of the FACILITY.

I further understand that all medical or healthcare (emergency or otherwise) that I receive at the FACILITY will be my sole responsibility and expense, unless I am eligible for Worker's Compensation coverage.
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, and that I have freely and voluntarily signed this Agreement.

Signature: _____ Printed Name: _____ Date: _____