

Hancock Health  
SCHOOL OF RADIOLOGIC TECHNOLOGY

**Student Internship Waiver and Release**

Please read this form carefully. Note that by signing this waiver and release (the "Release") and by participating in the internship described below (the "Activities"), you will be expressly assuming the risk and legal liability and waiving and releasing Hancock Health and the Hancock Health School of Radiologic Technology from all claims for injuries, damages, or loss which you might sustain as a result of any and all activities connected with and associated with the Activities.

SUPERVISOR OF INTERN (Print Name): Taylor Jones, program director

INTERN (Print Name): \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_

I, the above-named intern, am 18 years of age or older, and am performing as an intern at Hancock Health as a student radiographer of my own free will. I acknowledge that within the course and scope of my Activities as an intern, I may be exposed to hazards or risks that may result in my illness, personal injury, or death and I understand and appreciate the nature of such hazards and risks. I understand that, for purposes of this waiver and release, the word "Activities" shall mean and include all activities regularly required of radiography students as part of the internship program operated by the Hancock Health School of Radiologic Technology, including but not limited to the activities that require my ability to satisfy the list of "physical demands" set forth in the School's list of Technical Performance Standards. By signing my name below, I acknowledge that I am fully aware of the nature and scope of the Activities in which I will be engaged as a student radiographer.

In consideration of being permitted to participate in the Activities, I hereby accept all risk to my health, including any injury or death, and property that may occur while I am acting within the course and scope of the Activities as an intern or otherwise participating in the Activities. To the best of my knowledge, I can fully participate in the Activities. I hereby RELEASE, WAIVE, DISCHARGE AND COVENANT NOT TO SUE Hancock Regional Hospital d/b/a Hancock Health and the Hancock Health School of Radiologic Technology and their officers, directors, servants, agents, and employees (hereinafter referred to as RELEASEES), from any and all liability, claims, demands, actions and causes of action whatsoever arising out of or related to any loss, damage, or injury, including death, that may be sustained by me, or to any property belonging to me, WHETHER CAUSED BY THE NEGLIGENCE OF THE RELEASEES, or otherwise, while interning or otherwise participating in the Activities, or while in, on or upon the premises where the Activities are being conducted or in transportation to and from said premises. I further hereby AGREE

TO INDEMNIFY AND HOLD HARMLESS RELEASEES from any loss, liability, damage or costs, including court costs and attorneys' fees they may incur due to my participation in said Activities, WHETHER CAUSED BY NEGLIGENCE OF RELEASEES or otherwise.

It is my express intent that this release shall bind the members of my family and spouse (if any), if I am alive, and my heirs, assigns and personal representative, if I am not alive, and shall be deemed as a RELEASE, WAIVER, DISCHARGE AND COVENANT NOT TO SUE above named RELEASEES. I further understand and acknowledge that RELEASEES are not an insurer of my personal safety or property. I UNDERSTAND THAT THE RELEASEES WILL NOT BE RESPONSIBLE FOR ANY MEDICAL COSTS ASSOCIATED WITH ANY INJURY I MAY SUSTAIN. I also understand that I should and am urged by Hancock Health to obtain adequate health and accident insurance to cover any personal injury to myself which may be sustained during the Activities or the transportation to and from said Activities.

I further agree to become familiar with the rules and regulations of Hancock Regional Hospital d/b/a Hancock Health and the Hancock Health School of Radiologic Technology and not to violate said rules or any directive or instruction made by the person or persons in charge of said Activities and that I will further assume the complete risk of any activity done in violation of any rule or directive or instruction.

IN SIGNING THIS RELEASE, I ACKNOWLEDGE AND REPRESENT THAT I have read the foregoing document, that I understand it, and that I am signing it voluntarily as my own free act and deed; no oral representations, statements or inducements, apart from the foregoing written statements, have been made to me; I am at least eighteen (18) years of age and fully competent; and I execute this Release for full, adequate and complete consideration fully intending to be bound by the same. I understand this Release will be construed in accordance with the laws of the state of Indiana.

Signature of Intern: \_\_\_\_\_

Signature of Witness: \_\_\_\_\_

Relationship of witness to Intern: \_\_\_\_\_

Date: \_\_\_\_\_