Morton Plant Mease
HEALTH CARE
P.O. Box 760, Dunedin, Florida 34697-0760 Phone: 727-733-1111

DISEASE CONTACT RELEASE FORM

I understand that during the course of his/her clinical training, _____ will be working with individuals, patients, specimens and/or biohazardous materials that may have come from an individual with a communicable or infectious disease I also understand that each student will be expected to follow universal precautions at all times whenever in the clinical setting.

Morton Plant Mease Health Care asks that students who will be participating in the clinicals at their facilities sign the following:

I understand and agree that I will hold Morton Plant Mease Health Care harmless from any liability or damages resulting from any contact or exposure to biohazardous materials, specimens, patients, or individuals

Signature of parent
or legal guardian: _____

Relationship to student: _____

Student signature: _____

Date: _____

Signature of Notary Public: _____

Notarial Seal.