

**Assumption of Risk, Acknowledgment and Release**

I understand that there are certain risks and dangers inherent in my participation in career/job shadowing at SUNY Upstate Medical University. I understand that I could be injured as a result of participating in this activity. By signing this form, I acknowledge that I am voluntarily electing to engage in the above stated activity, and I am voluntarily assuming any and all reasonable risks of engaging in the activity. I also hereby release the State of New York, the State University of New York, the Upstate Medical University, University Hospital and all affiliates of those entities (including without limitation the SUNY Research Foundation and the Upstate Faculty-Student Association) and their officers, employees and agents from any and all liability, claims, damages, actions, or proceedings arising out of any injuries I may sustain through my participation in this activity, so long as such injuries were not the result of gross negligence on the part of such entity or individual.

Dated \_\_\_\_\_

\_\_\_\_\_  
Signature of Participant

\_\_\_\_\_  
Signature of Parent/Legal Guardian  
(if student is under 18 years of age)

\_\_\_\_\_  
Witness to Participant's Signature

School or College Affiliation \_\_\_\_\_