JOLIET JUNIOR COLLEGE
1901

JJC DIAGNOSTIC MEDICAL SONOGRAPHY OBSTETRICAL VOLUNTEER SCAN MODEL CONSENT AND RELEASE OF LIABILITY FORM

I, _____, agree to be a volunteer scan model at Joliet Junior College ("JJC") for the Diagnostic Medical Sonography program. I acknowledge an ultrasound scan is conducted for the purpose of educating students and will not be evaluated by JJC faculty, staff or students for medical purposes. ARDMS credentialed sonography faculty may or may not be present during the study. As such, the sonography faculty, under direct or indirect supervision and students will not fully evaluate the desired exam and make no representations that the volunteer is receiving any medical diagnosis or treatment. I acknowledge that JJC will use the scan for educational purposes, but will not disclose any personally identifiable information about me or my medical information to any other party without my express written consent. I further acknowledge that the images taken as a result of the ultrasound scan will remain the property of JJC.

I, for myself and on behalf of my heirs, assigns, personal representatives and next of kin, hereby release, indemnify, and hold harmless JJC, its officers, officials, agents students and/or employees ("Releasees") with respect to any and all future diagnostic concerns, whether arising from the negligence of the Releasees or otherwise, to the fullest extent permitted by law. I further state that I am at least eighteen (18) years of age and fully competent to sign this document; and that I execute this release for full, adequate, and complete consideration fully intending to be bound by the same.

I have notified my physician of my intent to participate in a sonographic student training session at JJC. I have presented this document to my current physician and s/he has reviewed it with me, and has approved my intent to participate as a volunteer at JJC for this specific sonographic scan. My physician's contact information has been provided below to JJC in case post-session contact is necessary.

I understand that there is possibility that the ARDMS credentialed supervising (direct or indirect) sonography faculty and/or students may incidentally discover potential areas of diagnostic concern during this learning opportunity; therefore, I hereby give permission to JJC and the appropriate support staff to forward such information to the below listed healthcare provider. Supervising (direct or indirect) faculty and students may, but are not required to, disclose what they discover, but are under no obligation to provide medical or treatment recommendations. I also understand that JJC will **NOT** be responsible with any further follow-up with me or my physician. I agree to be personally responsible for following up with my physician for all medical care.

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Name of Primary Health Care Provider or OB/GYN: _____

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Phone Number of Primary Health Care Provider or OB/GYN: _____

Physician Consent

I, _____, am the physician for the above named patient, and hereby agree that she is medically fit to obtain an ultrasound exam from JJC.

Physician's Signature:

_____

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Address of Health Care Provider:

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Volunteer Name: _____ Date of Birth: _____

Volunteer Address:

_____

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Volunteer Phone Number: _____ Emergency Phone Number: _____