



Northern Ontario
School of Medicine

Acknowledgement of Risks and Responsibility, Liability Waiver, and Indemnity Agreement (hereinafter collectively referred to as the “Agreement”)

Northern Ontario School of Medicine (“NOSM”) as the Faculty of Medicine
for Lakehead University (“Home University”) and Laurentian University
 (“Home University”)

**Re: Medical Education Electives Outside Canada
Assumption of Risks and Responsibility, Liability Waiver, and Indemnity Agreement**

**ATTENTION: BY SIGNING THIS LEGAL DOCUMENT, YOU ASSUME PARTICULAR
RESPONSIBILITIES AND GIVE UP CERTAIN LEGAL RIGHTS, INCLUDING THE RIGHT TO
SUE. PLEASE READ CAREFULLY!**

In consideration of the Northern Ontario School of Medicine (“NOSM”) and my Home University
approving a medical elective at

_____ (*host institution name/name of*

country) for a period beginning on _____ and ending on _____
(the “Program”), I agree as follows:

Assumption of Risks: I understand that the Program will take me away from campus for an
extended period of time. During this period, I understand that I will be in an unfamiliar surrounding
with different laws, customs, standards of public health, sanitation, communications and public
infrastructure and that I may be exposed to risks to my person and property. I understand that I
may suffer physical or mental injury, disease, sickness or death, or damage/loss to my property
as a result of my participation in the Program; and that there is a possibility of violence and crime,
civil unrest, homesickness and loneliness. I freely and voluntarily accept and assume all such
risks, dangers and hazards of any sort which may arise. I understand that NOSM and my Home
University will not be able to ensure my safety from such risks and dangers. I further
acknowledge that I had other options, and was not required to participate in the Program, but
selected to do so freely and voluntarily.

Assumption of Responsibility: I understand that my voluntary participation in these NOSM
electives requires a minimum level of personal health and well-being (physical, mental and
emotional) and I hereby warrant that I am fully able to participate in the Program. I understand
that travel arrangements and acquisition of a valid passport and all necessary study permits/visas
and residence permits are all my responsibilities. I acknowledge that I have been advised to read
the most current Canadian Department of Foreign Affairs and International Trade - Travel Report
to the extent that it refers to the country of the host institution, before I travel there. I understand
that it is my responsibility to abide by all applicable policies and laws of NOSM, my Home
University and the host institution/country, and to ensure that I have adequate medical, personal
health, dental and accident insurance coverage, as well as protection of my personal
possessions. More particularly, I understand and appreciate that NOSM and my Home University
do not carry health, accident, property or injury insurance for my benefit and I acknowledge that I
have been advised by NOSM of such risks and dangers as well as the need to act in a
responsible manner at all times. I confirm that I have arranged medical insurance for the duration
of my travel abroad, and that **I have provided proof of such insurance to NOSM**. My signature
below is given freely in order to indicate my understanding of the acceptance of these realities
and in consideration for being permitted by NOSM and my Home University to participate in the
above-mentioned Program. I recognize that NOSM and my Home University will not supervise
any portion of the Program while I am attending at:

_____ (*host institution name*) or in

_____ (*name of country*). Further, I recognize that NOSM and my

Home University will not arrange any living accommodations or extracurricular activities during my participation in the Program.

Liability Waiver: I release and hold harmless and covenant not to sue NOSM or the Home Universities, their governors, directors, employees, officers, students and agents (the "Releasees"), with respect to any and all liability for any loss, damage, injury or expense that I or my next of kin may suffer as a result of my participation in this Program, including but not limited to, death, illness, loss of life, injury to my person, illness, loss or damage to my personal property, or any consequential damages arising in any way from my participation in the International Medical Elective. accidents, acts of God, war, civil unrest, sickness, disease, transportation, scheduling, inconvenience, government restrictions or regulations, and any and all expenses which I may incur while participating in the Program, as a consequence of any cause, including the negligence of the Releasees. I understand that this waiver cannot be modified or interpreted except in writing by NOSM and the Home Universities and that no other variation shall be valid. This waiver shall be effective and binding upon my heirs, next of kin, executors, administrators and assigns, in the event of death.

Indemnity Agreement: I agree to hold harmless and indemnify the Releasees from any and all liability for any damage to the property of, or personal injury to, any third party, resulting from my participation in this Program.

I acknowledge and agree that I have received sufficient preparation and information regarding my intended elective and hereby accept full responsibility for complying with all of the terms set forth therein.

I acknowledge and agree that this Agreement shall be construed and enforced in accordance with the laws of Ontario and the laws of Canada applicable therein. Any claims, legal proceedings or litigation arising in connection with this Agreement will be brought solely in Thunder Bay or Sudbury, Ontario.

I HAVE READ THIS DOCUMENT CAREFULLY AND I ACKNOWLEDGE MY RESPONSIBILITIES AND THE EFFECT OF THIS LIABILITY WAIVER ON MY LEGAL RIGHTS AND RESPONSIBILITIES

Please Print

Student Name:

NOSM ID Number:

Permanent Mailing Address:

Permanent Phone Number:

E-Mail or Phone Number Overseas:

Emergency Contact Name:

Emergency Contact Phone Number:

Relationship:

Signature of Participant:

Witness as to Signature of Participant:

Date:

Date: