Assumption of Risk and Waiver Form for Employees

Semester and/or Date of Event: _____
Department: _____
Class/Activity: _____

Check the appropriate off campus travel purpose: ☐ travel for academic courses ☐ AAUP travel reimbursable from the "Travel Fund" ☐ travel related to professional conferences ☐ travel related to my role as a University employee ☐ Other _____

I understand that off campus travel as a Rider University employee, in which I have chosen to participate, involves certain risks, including, but not limited to, injuries resulting from auto/bus/train accidents as well as slips and falls. I will adhere to all guidelines set forth in the relevant Rider University Travel Policy.

Therefore, with acknowledgment of the potential risks involved with these activities, I expressly and knowingly release, hold harmless and agree to indemnify Rider University, its trustees, officers, employees, representatives, advisers and agents, from any and all claims and causes of action arising out of any travel for property damage, personal injury or death sustained by me and/or caused by my intentionally wrongful acts or by acts outside the scope of my employment.

☐ Travel provided by the University

- In the event of an unavoidable reason that prevents me from taking the transportation provided by the University, I assume all responsibility to transport myself to and from the event and understand that cost associated with such transportation will not be reimbursed.
- I understand that it is my responsibility to arrive on time at the designated location(s) for both departures to and from the activity. Should I neglect to arrive promptly at the designated location(s), I understand that I risk being excluded from transportation to and from the destination of the trip, and assume all risks and responsibility thereby incurred.

FOR: EMPLOYEE

NAME: _____ BY: _____
(Print Employee Name) (Employee Signature)

EMPLOYEE'S CELL PHONE: _____ DATE: _____

EMERGENCY CONTACT: _____ PHONE: _____

Please list any special services you may require due to an existing medical condition or physical disability, using the back if necessary.

The Health Insurance Portability and Accountability Act (HIPAA) allows for the disclosure of your protected health information from a health care provider (hospitals) to individuals involved in your care or for the purpose of notifying family members. In the event you are hospitalized, administrative staff at Rider may need information about your health in order to provide family members with timely and accurate information about your condition. Please be aware that signing this form is completely VOLUNTARY, remains in effect until such time as your enrollment at or association with Rider University ends and may be revoked, in writing, at any time. This form will remain on file with the university and presented to the health care provider in the event you require medical treatment.

I _____, give permission to this health care provider to provide administrative staff at Rider University information related to the condition of my health in the event my health condition requires medical attention.

EMPLOYEE SIGNATURE: _____ DATE: _____

I _____, hereby give my consent for any medical treatment that may be required during my participation with the understanding that the cost of any such treatment will be my responsibility.

EMPLOYEE SIGNATURE: _____ DATE: _____