



SIMULATION EDUCATION TEACHING HOSPITAL

Standardized Patient/Client

Acknowledgment of Policies and Procedures

After reading the handbook, sign and return this form to Standardized Patient/Client Educator, SETH. This form will be part of your permanent record. I have had the opportunity to ask any questions that I may have and understand the provided answers.

By signing this form, I accept the policies of the University and the responsibilities associated with my duties as a standardized patient or client. I have read the handbook and the appendices and I am aware of what will be required of me.

I understand that Franciscan Missionaries of Our Lady University reserves the right to dismiss me for incompetence, misconduct or violation of the University policies and procedures.

Standardized Patient/Client's Signature

Date

Standardized Patient/Client's Name (Printed)

Date



Franciscan Missionaries of Our Lady University is a private, Catholic university committed to excellence in teaching students ("Students") the art of displaying Franciscan values as they interact and communicate with peers, faculty, employers and the public. Standardized clients ("Standardized Clients") are sought to prepare the Students to be successful in their chosen vocation.

For Students to learn to communicate and interact appropriately in a variety of situations, it is important that Students have the opportunity to practice their skills in a simulated environment with "real" people in a variety of situations. Standardized Clients play a vital role in the educational process as they provide feedback to Students, making the Student aware of the needs of potential clients.

I voluntarily agree to participate as a Standardized Client in a role for which I will be trained and directed. I understand that Standardized Client scenarios are for learning purposes only. I am aware that the risks are minimal and nothing invasive will be performed. As a Standardized Client, I am aware that I am expected to work in a professional manner, interacting with the Students to enhance their learning.

Further, I consent to photographs, videotapes, slides, digital or other images that may be recorded to document my participation, and I authorize the use of these images, without compensation to me. I understand that these images may be used to exhibit, publish in newspapers, magazines, other publications, television, motion pictures, Internet or other media which will be circulated to the general public for educational, business, marketing and for any other purpose.

I certify that I have read this consent form. The purposes and expectations of this Standardized Clients program have been explained to me as a Standardized Client. I understand that I am able to ask questions or withdraw my participation at any time.

I, the undersigned participant, for myself or my minor child, voluntarily agree to the terms and conditions stated above and am freely signing this agreement.

Signature of Standardized Client/Legal Representative

Date

Relationship to Standardized Client: _____

Faculty Signature

Date

Printed name: _____



FRANCISCAN
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Standardized Patient Consent, Assumption of Risk and Hold Harmless

Franciscan Missionaries of Our Lady University is a private, Catholic university committed to excellence in teaching students ("Students") the art of providing quality patient care. To learn to assess and treat patients, it is important that Students have the opportunity to conduct training healthcare assessments and interventions using volunteer standardized patients ("Standardized Patient(s)") in an educational setting ("Training Assessments"). Standardized Patients are sought to participate in Training Assessments to help prepare the Students to care for patients in the clinical setting, and Standardized Patients provide valuable feedback to Students by making the Student aware of the needs of potential patients.

I understand that Standardized Patient scenarios are for learning purposes only and should not be used in the place of routine medical care. I understand that I will be examined by a Student who is not an experienced medical practitioner and is not able to render a personal medical opinion or medical treatment. I understand and agree that I am responsible for my own care, and that I will refer my questions to my personal medical practitioner.

I voluntarily agree to participate as a Standardized Patient in Training Assessments in a role for which I will be trained and directed. I am aware that the risks are minimal and nothing invasive will be performed. As a Standardized Patient, I am aware that I am expected to work in a professional manner, interacting with the Students to enhance their learning.

Further, I consent to photographs, videotapes, slides, digital or other images that may be recorded to document my participation, and I authorize the use of these images, without compensation to me. I understand that these images may be used to exhibit, publish in newspapers, magazines, other publications, television, motion pictures, Internet or other media which will be circulated to the general public for educational, business, marketing and for any other purpose.

I hereby agree to accept and assume any and all risks of property damage, personal injury or death, and I specifically release Franciscan Missionaries of Our Lady University and, its directors, officers, employees, teachers, students and agents from any and all liability for any claim, demand, cause of action of any kind whatsoever for, or on account of death, personal injury, property damage or loss of any kind resulting from or related to my participation as a Standardized Patient in a Training Assessment at Franciscan Missionaries of Our Lady University facilities.

I agree to hold Franciscan Missionaries of Our Lady University and its affiliates and its/their respective directors, officers, employees, teachers, students and agents harmless from the same.

I certify that I have read this consent, assumption of risk and hold harmless form. The purposes and expectations of this Standardized Patient Student Training Assessment have been explained to me with regard to my participation as a Standardized Patient. I understand that I am able to ask questions or withdraw my participation at any time.

I, the undersigned participant, for myself or my minor child, voluntarily agree to the terms and conditions stated above and am freely signing this agreement.

Signature of Standardized Patient/Legal Representative

Date

Relationship to Standardized Patient: _____

Clinical Faculty Signature

Date



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Standardized Patient/Client Information Sheet

Personal Information

Name _____ Nickname: _____
Phone _____ Is texting ok? Check: Yes or No
Age _____ Gender _____ Ethnicity _____
Email: _____
Major (if applicable): _____
Address: _____

Availability

Time(s) available: (circle response) Day(s) available: (circle response)
Morning Afternoon M Tu W Th F
Are you available year round? (check response) Yes No
Do you have reliable transportation? (check response) Yes No
Do you have any training or experience in the healthcare field?
(check response) Yes No

Other Information

If you have a medical issue that I should be aware of, or if you have any other questions or concerns, please include them here:

What interested you in becoming a standardized patient/client?