HOSPITAL

Hospital Patient Pet Care

RELEASE OF LIABILITY, WAIVER OF CLAIMS AND ASSUMPTION OF RISK AGREEMENT

Please read carefully before signing.

By signing this document, you will waive certain legal rights, including the right to sue.

To: HOSPITAL and all officers, directors, agents, employees, volunteers and/or representatives (collectively, HOSPITAL):

1. I AGREE TO PARTICIPATE IN HOSPITAL PATIENT PET CARE PROGRAM (the "Program"). I understand that by participating in the Program I am agreeing to allow representatives of HOSPITAL to care for my pet(s) while I am a patient at HOSPITAL. I also understand that in order to care for my pet(s), representatives of HOSPITAL and, as deemed necessary by HOSPITAL, representatives from THIRD PARTY SERVICE PROVIDER, must enter my residence, and I hereby give such representatives of HOSPITAL and THIRD PARTY SERVICE PROVIDER permission to do so.

2. I HEREBY WAIVE ANY CLAIMS AGAINST HOSPITAL AND THIRD PARTY SERVICE PROVIDER AND RELEASE EACH OF HOSPITAL AND THIRD PARTY SERVICE PROVIDER FROM ANY AND ALL LEGAL LIABILITY to me and my family members for any loss, damage, injury or expense to me, my property, my family members or my pet(s) as a result of my participation in the Program, due to any cause whatsoever (including any and all claims based on negligence or any other legal theory), and agree not to sue or bring any legal action against HOSPITAL or THIRD PARTY SERVICE PROVIDER in connection with the Program.

3. In the event of my death or incapacity, this Agreement shall be effective and binding upon my heirs, next of kin, executors, administrators, assigns and representatives.

4. In entering into this Agreement and agreeing to participate in the Program, I am not relying upon any oral or written representations of HOSPITAL or THIRD PARTY SERVICE PROVIDER.

I HAVE READ AND UNDERSTAND THIS AGREEMENT, AND I AM AWARE THAT BY SIGNING THIS AGREEMENT I AM WAIVING CERTAIN LEGAL RIGHTS, INCLUDING THE RIGHT TO SUE HOSPITAL OR THIRD PARTY SERVICE PROVIDER.

_____ _____

Signature of Patient or authorized representative Date

_____ _____

Witness Date