



## Local Outreach Missions ASSUMPTION OF RISK STATEMENT

I, \_\_\_\_\_, know the itinerary and have requested to participate in the activity described below. I have been fully and completely apprised of the actual and potential risks inherent in this activity. I understand that there will be patient contact.

These include the risk of property damage or loss, personal injury or death. By signing below, I am asserting that I am knowingly and voluntarily assuming all such risks. I further assert that I have been advised that I must ensure that I am covered by a health/accident insurance coverage, which will be available to cover the costs of any medical expenses, or other costs which I incur should I be injured while participating in this activity.

I agree not to hold the University responsible for insuring any losses I may suffer in relation to this participation. I understand that the School of Dental Medicine, the State University of New York, the State of New York (and their officers, agents, employees and volunteers) do not maintain liability coverage associated with these activities.

I assume full and complete responsibility for obtaining proper health/accident and, if appropriate, motor vehicle insurance coverage.

PROGRAM: at \_\_\_\_\_ on \_\_\_\_\_ from \_\_\_\_\_.  
(Location) (Date) (time)

Participant Signature: \_\_\_\_\_ DATE: \_\_\_\_\_

Cell Phone Number: \_\_\_\_\_

Emergency Contact Name and Phone Number: \_\_\_\_\_