**Observation Interview Acknowledgement and Waiver**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, understand that my presence today is considered an interview, during which I may be exposed to the following conditions:

* Fractious canine and feline patients
* Potential physical hazards such as moisture on floors, sharp objects such as needles
* Potential biological hazards, such as pharmaceutical drugs, canine and feline bodily fluids, and cleaning/ sanitation supplies.

I recognize that these hazards are similar to those I would be exposed to should I obtain a position at this practice, and will act in compliance with OSHA regulations around these hazards.

I understand that, as I am not an employee of this practice, I am here to observe only, with the recognition that I am not to have direct contact with any patient or hazardous material outlined above.

I understand that, as I am not an employee of this practice, I am not covered by the Workers Compensation insurance this practice carries for individuals employed by the practice. Should an injury occur, I understand that I am responsible for my medical care to treat said injury. I hold \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ in no way responsible for any injury or illness that occurs as a direct or indirect result of my activities here.

I further understand that this interview and my presence here today in no way implies or promises employment with this practice, now or in the future.

I understand that I am volunteering my time as an observer at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ today, and that I will not be paid.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
Candidate Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Candidate Name- Printed

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Practice Owner Signature Date