

Participant Waiver Form

I, _____, hereby acknowledge that I have voluntarily enrolled in the certification course provided by Primary Care Resources, on ____ / ____ / _____, and I understand and agree to the following terms and conditions:

1. **Assumption of Risk:** I understand that participation in the certification course involves certain inherent risks, including but not limited to physical exertion, tripping hazards, environmental hazards, and the possibility of accidents or injuries.
2. **Release of Liability:** I hereby release, waive, discharge, and covenant not to sue Primary Care Resources and its instructors from any and all liability, claims, demands, actions, and causes of action arising out of or related to any loss, damage, or injury, including death, that may be sustained by me or any property belonging to me while participating in the certification course.
3. **Certification:** I understand that Primary Care Resources provides education and training for certification purposes in adherence with the American Heart Association and that it is my responsibility as the certified (lay-rescuer/healthcare-professional) to maintain competency in the skills and knowledge related to the certification. Primary Care Resources acknowledges that at the time of certification, the persons certified, meets, and uphold the standards set forth by the American Heart Association for certification. Additionally, any actions post-certification that may be found negligent is not a reflection of Primary Care Resources, its instructors, or employees and the responsibility of such negligence lies with the certified (lay-rescuer/healthcare-professional).
4. **Assumption of Responsibility:** I acknowledge that I am solely responsible for my own actions and decisions following the completion of the certification course, and I agree to indemnify and hold Primary Care Resources harmless against any claims or liabilities arising from my conduct post-certification.
5. **Medical Clearance:** I certify that I am in good physical health and have no medical conditions that would prevent me from safely participating in the certification course. I understand that it is my responsibility to disclose any medical conditions that are prior, current, or developed during the course, that would impede my ability to safely participate in the completion of the course.
6. **Photography and Video:** I grant Primary Care Resources the irrevocable right and permission to use photographs and/or videos of me taken during the course for promotional and marketing purposes, without compensation to me.

I have closely read the above, Participant Waiver Form, waiver and fully understand its terms. I further acknowledge that by signing the form below I am voluntarily agreeing to waive significant legal rights.

(TO BE COMPLETED PRIOR TO THE START OF THE COURSE)

Participant's Information:

Name: _____

Signature: _____

Date: ____ / ____ / _____

Parent/Guardian Signature: _____
(if participant is under 18 years old)

Date: ____ / ____ / _____

Course Information:

Course: _____

Location: _____

Date: ____ / ____ / _____