**EVENT ATTENDEE WAIVER AND RELEASE OF LIABILITY FORM**

The Fall Institute for Psychiatric Advanced Practice Nurses continues to monitor policy and procedures during the COVID-19 pandemic. The safety and well-being of our participants, is our top priority. We are following the guidelines of federal, state, and local agencies to implement best practices aimed at managing the spread of the novel and complex virus.

The Fall Institute for Psychiatric Advanced Practice Nurses has put in place preventative measures to reduce the spread of the COVID-19 virus; however, The Fall Institute, under no circumstances, is able to guarantee that you or a guest will not become infected with the virus while attending events or visiting surrounding areas.

Adherence to event policy and guidelines is required for participation. Please review agreement below. Additionally, your signature will be required as a confirmation of your intent and commitment to abide by policies put in place to protect university participants/guests, speakers, and staff.

Agreement:

● I declare I am not experiencing or exhibiting any COVID-19 related symptoms as outlined by the federal and state Center for Disease Control and Prevention (CDC) such as fever, dry cough, or shortness of breath.

● I acknowledge I must follow the safety protocols that have been implemented by The Fall Institute and The Pines Lodge property including wearing a mask at all time in the building except when eating and drinking, practicing social distancing and maintaining separation of six feet from individuals.

● I declare I have not traveled internationally or to a highly impacted COVID-19 area within the United State during the last (14) days.

● I am not aware nor do I believe I have been recently exposed to a person or animal with a positive and confirmed case if COVID-19.

● I acknowledge I may be removed from an event or asked to leave the Pines Lodge property by hotel staff or Fall Institute representative should I exhibit any behavior in direct contrast to guidelines and safety measures.

Signature:

By signing this event attendee waiver and release of liability form, I acknowledge the contagious and evolving nature of COVID-19 and voluntarily assume the risk that I may be exposed to virus and become affected as a result. I understand the risk of becoming infected may impact the community, event guests, and event attendee’s families or personal contacts.

I voluntarily agree to assume all of the foregoing risks and accept sole responsibility for any expense, liability, illness, injury, disability or death related to contracting the virus while attending an event organized by the Fall Institute for Psychiatric Advanced Practice Nurses. I hereby release, covenant not to sue, discharge, and hold harmless The Fall Institute for Psychiatric Advanced Practice Nurses from all claims any kind arising out of COVID-19. I understand and agree that release of liability includes any claims towards The Fall Institute and its representatives, speakers, and participants whether a COVID-19 infection occurrence exists before, during, or after attendance and participation at an event.

This event attendee waiver and release of liability form shall be governed by and construed under the laws of the State of Colorado, without regard to its choice of law principals. I agree not to commence or prosecute any action in connection herewith other than in the state and/or federal courts of the State of Colorado, Eagle County.

I and my guests agree to be bound by all terms of this event attendee waiver and release of liability form, as indicated by our signatures below.

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_