



**University of Pittsburgh Schools of the Health Sciences
Research Training Program (“Program”) for Students**

Learning Agreement and Parental Consent

Trainee’s Name

Trainee’s Email Address

Faculty Mentor’s Name

Faculty Mentor’s Title

University of Pittsburgh Department/School

Campus Address

Phone

Pitt Email

Brief description of research interests

Specify the start and end dates

Hours per week

Research key words (add up to five)

Describe the responsibilities of the Trainee during this experience, including the hands-on training to be provided.

Describe the Trainee educational goals for this experience. Identify the skills and abilities the Trainee will pursue. Describe how the Trainee's responsibilities complement the Faculty Mentor's and their staff's work by providing a significant educational benefit to the Trainee.

Describe how you will train, mentor, supervise and evaluate the Trainee. How often will this be done?

Describe in detail the culminating academic and education research project (laboratory-based or clinical research experiences as well as other creative activities), including the expected scope and outcomes.

Describe the typical week with respect to hours (The Program is designed to accommodate the Trainee's academic commitments, if any, and shall be limited to the period in which the research experience provides the trainee with beneficial learning).

Guiding Principles of the Schools of the Health Sciences Research Training Program

1. This Program strives to be similar to training which would be given in an educational environment;

2. The experience is for the benefit of the Trainee and the Trainee is the primary beneficiary of the Program;
3. The Trainee does not displace regular employees, but works under close supervision of existing staff to learn how to carry out scholarly activities;
4. The University derives no immediate advantage from the activities of the Trainee; and on occasion its operations may actually be impeded;
5. The Trainee is not entitled to a job at the conclusion of the experience; and
6. The University and the Trainee understand that the Trainee is not entitled to wages for the time spent in the Program.

The Department will ensure that the Program is administered consistent with the following guidelines: <https://www.ehs.pitt.edu/sites/default/files/docs/01-010RestrictedAreas.pdf>

*******CONSENT FOR MEDICAL TREATMENT**

I grant the Program permission to provide any medical services needed if such becomes necessary. I give permission to the staff members of the University of Pittsburgh Research Training Program to act as my representative in signing any medical services needed and to contact my family physician if needed. I represent that I have health insurance and I am covered by my health insurance.

I understand that even if I do not have health insurance, the University of Pittsburgh does not cover the cost of medical treatment for participants in the Program. I understand that if a participant requires medical treatment when the University of Pittsburgh Student Health Services is closed, the participant will be taken to the emergency room.

I authorize the clinical staff of the University of Pittsburgh Student Health Services or other licensed practitioner of the healing arts, acting within the scope of his or her practice under State law, to provide medical care that includes routine diagnostic procedures (e.g., x-rays, blood, and urine tests) and/or anesthetic and/or medical treatment to me as subsequently deemed necessary by a licensed health care provider during the participant's session. I understand that the consent and authorization herein granted is given in advance of any specific diagnosis, treatment, or hospital care.

In the event that an illness or injury would require more extensive treatment (e.g. surgical procedures), I understand that every reasonable attempt will be made to contact me. However, in the event of an emergency and/or if I cannot be reached, I give my consent for physicians and staff at the University of Pittsburgh Student Health Services or other licensed practitioners of the healing arts to perform any necessary emergency treatment.

I understand that the University of Pittsburgh Student Health Services or other licensed practitioner of the healing arts, acting within the scope of his or her practice under State law, does charge for services. I acknowledge my responsibility to pay all costs associated with my son/daughter/dependent's medical care and authorize all insurance payments, if any, to be made directly to the medical facility. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes to the appropriate medical care provider. I authorize the University of Pittsburgh to receive medical/billing information and submit it to the University's insurance carrier.

PARENT/GUARDIAN CONSENT FOR PARTICIPATION

It is with my full knowledge and approval that my son/daughter/dependent is participating in *Research Training Program* on the University of Pittsburgh Oakland Campus. I grant permission for my son/daughter/dependent's participation in all phases of the Program. I understand that all programming will be supervised and implemented in a manner compatible with the nature of the Program and the age and maturity of the participants.

RELEASE

I understand that good faith efforts will be made to insure the safety and good health of the participants of the *Research Training Program*. I therefore agree to assume and take on myself all of the risks and responsibilities in any way associated with the *Research Training Program*. In consideration of the opportunity to engage in the *Research Training Program* and for the services, facilities, equipment, or other things provided to me by the University of Pittsburgh, I agree not to hold the University of Pittsburgh, and/or *Research Training Program* staff responsible for any injuries, damages or losses I and/or my son/daughter/dependent may incur. I recognize that this means I am giving up, among other things, rights to sue the University of Pittsburgh, and/or *Research Training Program* staff for injuries, damages, or losses I and/or my son/daughter/dependent may incur. I understand that this release covers liability, claims, and actions caused entirely or in part by any acts or failures to act of the University of Pittsburgh and/or *Research Training Program*.

Mentor's Signature

Trainee's Signature

Distribute one copy each to the Trainee, faculty member and the departmental administrator.

Add additional pages/content if needed.