

**SCIENTIFIC DIVER MEDICAL CONSENT AND INSURABILITY**

I, \_\_\_\_\_, the undersigned, consent to and authorize any first aid provider, medical professional and others working under their supervision to treat me for any injury or illness occurring during my University of Maine System and University of Maine (UMAINE) affiliated diving activities.

**Initial one of the following:**

\_\_\_\_\_  
**EMPLOYEE:** I am an employee of \_\_\_\_\_ or other compensated affiliate or volunteer and I am authorized to conduct scientific diving as part of my official duties. Through my employment, I am eligible for worker's compensation coverage for job-related injury or illness incurred during my authorized diving activities under UMAINE auspices. As evidence of this, I attach the Verification of Employment for Scientific Divers.

\_\_\_\_\_  
**NON-EMPLOYEE:** I am a student, or other uncompensated adjunct/affiliate of \_\_\_\_\_, who is not eligible for worker's compensation coverage. In consideration of being allowed to engage in scientific diving under University auspices, I agree to RELEASE, DISCHARGE AND HOLD HARMLESS the University of Maine System, its officers, agents, assigns, and employees from and against any liability arising from my participation or any claims or demands arising from or connected with such medical treatment or care. As evidence of insurability I attach a copy of my insurance policy/card which covers the cost of emergency transport and medical care for diving related injuries or illness (ie. DAN). I agree to be responsible for payment of any and all medical expenses, costs and other charges not covered.

Member/Policy Number: \_\_\_\_\_ Coverage Level: \_\_\_\_\_ Expires: \_\_\_\_\_

**EMERGENCY CONTACTS**

1st Emergency Contact: \_\_\_\_\_ Relation: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

2nd Emergency Contact: \_\_\_\_\_ Relation: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Please list any Allergies or Sensitivities that may affect you in the field, or during emergency treatment (antibiotics, bee stings, etc.), of which the Diving Supervisor should be aware:

\_\_\_\_\_

With reference to any activities that are not a part of any official duties, **I affirm that I have read this form and fully understand that by signing this form I may be giving up legal rights and/or remedies regarding any losses I may sustain.** I agree that if any portion is held invalid, the remainder will continue in full force and effect. I agree that I have freely and voluntarily caused this release to be executed this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

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

Parent/Guardian Signature: \_\_\_\_\_  
(if diver is under age 18)

Diver Name: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_