

**Community Client Alliance**

**AUTHORIZATION TO PARTICIPATE IN TEACHING**

**AND LABORATORY ACTIVITIES / PHOTOGRAPHY RELEASE**

Please initial next to each item to which you agree to participate. You do not have to participate in all items to be a member of the Community Client Alliance (CCA).

 I agree to participate in teaching demonstrations involving examinations, evaluations, and therapeutic interventions provided by faculty members or students under the supervision of faculty members. I recognize that these activities are intended to provide hands-on learning opportunities for students and do not constitute formal physical therapy examination or intervention. I recognize that I have the right to refuse to participate in any activity at any time.

 I understand that every effort will be made by faculty and students to maximize my safety during classroom learning experiences. Should an injury occur, I understand that it is my responsibility to seek medical care and all associated costs.

 I authorize Western Michigan University, College of Health and Human Services, and/or faculty members of the Doctor of Physical Therapy program to make photographs, video and/or audio recordings, conduct interviews, or present my case as a teaching experience in physical therapy courses. All photographs, video/audio recordings, written interviews, etc. remain the property of Western Michigan University Doctor of Physical Therapy Program and I hereby assign all rights of publicity in these materials to Western Michigan University.

 I agree to allow faculty members of the WMU Doctor of Physical Therapy program to contact me regarding potential participation in research studies. I recognize that I have the right to refuse to participate in any research related activity at any time and this will not affect my participation in classroom activities as a member of the CCA.

Signature Date

Printed name: Date of Birth

Person/Faculty member who invited you into CCA:

**Complete this portion for minor children, or persons unable to acknowledge authorization**.

I, certify that I am

(Relationship)

of and authorize the above release in his/her behalf. (Minor child or subject)

Signature Date

Witness



# CONTACT INFORMATION

The following information will be used to contact you for CCA activities and events.

Daytime Telephone Number:

E-Mail Address:

Mailing Address:

Preferred Method of Contact:

Who should we speak with regarding scheduling CCA visits?

# HISTORY INFORMATION

The following information will be used for teaching purposes and will not be maintained as confidential information. Please do not list any information that you are not comfortable being shared with students.

Diagnosis or Condition Year of Onset Cause, if known

Other Medical issues we should be aware of:

What is your primary means of mobility?

 Walking Walking with a cane, crutches, or walker

 Walking with assistance from others Wheelchair