PRAIRIE MOUNTAIN HEALTH

WAIVER OF LIABILITY: PRIVATE PROVIDERS: PROVISION OF HEALTH SERVICES

Use with PPG-01362

Client: _____

_____

DOB (yyyy/mmm/dd): _____

HRN / MHSC: _____

PHIN#: _____

Addressograph/Place Label Here

I, _____ , the client or family or the authorized alternate decision maker for _____ (client name) have requested that _____ (specify the service) be provided by _____ (private health care provider PHCP). As such, I have:

- Reviewed the Client Family/ADM and Private Health Care Provider fact sheets provided by PMH
- Requested the PHCP review and comply with Private Provider's fact sheet, PMH policies and Manitoba/Canada Legislation listed within this fact sheet.
- Recognized and assume complete responsibility for the full payment of the above-mentioned services provided by PHCP.
- Recognized and acknowledge that the PHCP service (s) is being provided at my request by a care provider who is not acting as an agent or employee of PMH

I, _____ , a PHCP, agree to provide the service requested above in alignment with the requirements outlined in the PMH Fact Sheets.

The PHCP and client agree to defend, indemnify (protect) and save PMH harmless from any loss, cost, expense, judgment or damage on account of injury to persons including death or damage to property, in any way caused by the actions or negligence of the PHCP, its servants, agents or employees related to or arising out of services or other matters to which this agreement pertains, together with coverage on behalf of the PHCP for all legal expenses and costs incurred by PMH in defending any legal action pertaining to the above.

Print Full Name of Client/Family/ADM:	
Signature of Client /Family/ ADM:	Date (yyyy/mmm/dd):
Print Full Name of PHCP:	
Signature of PHCP:	Date (yyyy/mmm/dd):
Print Full Name of PMH Manager or designate:	
Signature of PMH Manager or designate as witness to the above:	Date (yyyy/mmm/dd):