

COVID-19 Waiver/Release

I, acknowledge that Jennifer (the "Therapist"), in returning to work, has confirmed to me that she has adhered to all health standards and guidelines set out by the Provincial Government of British Columbia relating to COVID-19'. The Therapist has confirmed to me that they have complied with all hygiene and practice standards imposed by the Provincial Government of British Columbia . Notwithstanding the Therapist has complied with Personal Protection Equipment requirements and complies with the appropriate guidelines. The Therapist has informed me that they cannot guarantee there will be no contraction of COVID-19 arising out of-the treatment.

This form constitutes a release and waiver of the Therapist from liability should COVID-19 be contracted through treatment. I acknowledge I have been requested to execute this release and it is a condition of me receiving treatment from the therapist, and failure to execute this Waiver and Release may result in treatment being refused.

1. I ACKNOWLEDGE and AGREE I understand the nature of the treatment I have requested.
2. I CONFIRM I am not currently showing any symptoms of COVID-19, and I have not, to my knowledge, contracted COVID-19, and I am aware of the COVID-19 symptoms.
3. I HEREBY RELEASE, WAIVE and DISCHARGE the Therapist, her administrators, employees, successors, heirs and assigns from all liability, actions, demands and proceedings arising from my contracting COVID-19 as a result of my treatment.
4. I ACKNOWLEDGE I have read this Waiver and Release and fully understand its terms and I have signed it freely and without any inducement or assurance of any nature; and I intend it to be a complete and unconditional release of all liability to the greatest extent allowed by law relating to my contacting COVID-19 from treatment. If any portion of this Waiver and Release is held to be invalid, the balance, notwithstanding, shall continue in full force and effect.

This Waiver and Release shall be governed by and construed under the laws of the Province of British Columbia.

PRINTED NAME OF CLIENT \_\_\_\_\_

CLIENT SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

PRINTED NAME OF THERAPIST \_\_\_\_\_

THERAPIST SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_