CSU EAST BAY MPA PROGRAM OFF-CAMPUS LEARNING EXPERIENCE
INFORMED CONSENT, WAIVER OF LIABILITY, AND RELEASE

I, the undersigned participant, am requesting participation in an off-campus learning experience to meet the course requirements of PUAD 6893 (Internship in Public Administration), which is an opportunity to received course credit for an internship experience in the MPA program. The learning experience is participation in a 300-hour internship at a public or related public service organization.

I understand that while participating, I am participating as a student and not as an employee, volunteer or agent of the University. I understand that I have none of rights, privileges and benefits, including workers' compensation coverage, associated with such designations.

I agree to act in a responsible manner while representing California State University and abide by all rules and regulations that govern the site in which I have been placed. I agree to adhere to the student conduct requirements that are available at: http://www20.csueastbay.edu/students/campus-life/student-life/sdja/student-conduct.html.

The potential risks of participating in the internship include, but are not limit to:
- Travel to and from home and off-campus learning experience
- Food poisoning
- Theft
- Exposure to contagious diseases
- Car accident
- Pedestrian accident
- Tripping, flipping, falling, etc.

Knowing, understanding and fully appreciating the potential of risks, I hereby expressly, voluntarily and willingly assume all risks and dangers associated with my participation in this activity up to and including death. Some of the risks and dangers are listed above. I understand this list is not all inclusive and may not cover all events offered.

I understand that medical coverage and services provided by the Student Health Services of CSU East Bay are limited. I understand that medical services not available from the CSU East Bay Student Health Services would need to be provided by a separate medical plan such as a family health plan. I understand that I should use my personal medical insurance as a primary medical coverage payment if an accident or injury occurs.
Off-Campus Site Information

Name of Organization: _________________________________________________________

Name of Intern Supervisor: _____________________________________________________

Position of Intern Supervisor: __________________________________________________

Intern Supervisor Phone #: ______________________  E-Mail: ________________________

Organization Address: _________________________________________________________

Organization City, State, & Zip Code: ___________________________________________

I have read this consent, waiver and release and understand the terms used in it and their legal significance. This informed consent, waiver and release are freely and voluntarily given with the understanding that the right to legal recourse against the State is knowingly given up in return for allowing my participation in the activity.

My signature on this document is intended to bind and not only myself but also my successors, heirs, representatives, administrators, and assignees. I affirm that I am 18 years or older.

STUDENT: ________________________________  DATE: _________________

NET ID: _________________  EMAIL: ________________________________