

**The George Washington School of Medicine and Health Sciences  
Research Release and Facility Access Form**

GW SMHS is committed to providing a safe and healthy laboratory environment for all members of the campus community and visitors. This form, along with laboratory safety training, must be completed before a visitor can access an SMHS laboratory. SMHS Office of Resource Management and Operations ([holumilu@gwu.edu](mailto:holumilu@gwu.edu)) will retain forms.

Participant Information		
Name:	Cell Phone:	
Permanent Address:	Email:	
Home University:	GWID Number:	
Start Date- End Date:	Scheduled Daily Hours :	
Emergency Contact		
Contact Name:	Contact Cell Phone:	
Relationship:	Alternative Phone:	
School of Medicine and Health Sciences Facility		
Department:	Lab Location:	Lab Phone:
Participant Role		
<input type="checkbox"/> Undergraduate-GW	<input type="checkbox"/> Undergraduate-Other	<input type="checkbox"/> Other: _____
<input type="checkbox"/> MD Research Fellow	<input type="checkbox"/> International Visiting Scholar	

<b>BOTH general laboratory safety and biosafety/bloodborne pathogen training must be completed and verified before participant may begin research activity</b>	
Office of Laboratory Safety OLS ( <a href="https://labsafety.gwu.edu">https://labsafety.gwu.edu</a> )	
Biosafety/Bloodborne Pathogens	Date completed:
Office of Health and Safety OHS ( <a href="https://safety.gwu.edu/training">https://safety.gwu.edu/training</a> )	
General Laboratory Safety	Date completed:

This form addresses laboratory safety issues associated with volunteers, interns, visiting scholars and students working in any SMHS laboratory.

By signing this form, I certify that:

- I am 18 years of age or over
- I am volunteering to participate in this educational activity in a research laboratory
- I understand there are certain hazards and risks involved in a research laboratory
- I am responsible for following all rules and instructions while participating in the activity, and my failure to do so will result in my participation in the activity ending
- If at any time, the research mentor decides that it is in my best interest, or the best interest of GW for me to no longer to participate, my participation will immediately end
- GW will not provide any accident, health or other insurance for me, and that it is my responsibility to pay for treatment of any injuries or illness that result from my participation in the activity
- I agree that I am voluntarily participating in this educational activity and I am not being compelled to do so, and in consideration of my participation, I will hold harmless and indemnify GW, its trustees, faculty, staff and students, from and against all claims, damages or liability arising from, or in any way related to, my participation in the activity or presence at GW in relation to the activity.

Participant Signature:	Date Signed:
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As Research Mentor/Principal Investigator:

- I agree to sponsor the participant and provide full time supervision, either by me or another staff to whom I have specifically delegated this responsibility
- I will provide information regarding specific lab hazards that will be encountered while participating in research
- I will provide access to personal protective equipment and training as necessary

Please describe the scope of work that this individual will engage in:

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School of Medicine and Health Sciences Approval	
Research Mentor Name:	Research Mentor Signature:
Chair/ Director Name:	Chair/ Director Signature: