MEDICAL STUDENT MENTORSHIP PROGRAM

Registered Independent Organization at the University of Hawai'i at Mānoa

651 Ilalo Street
Honolulu, HI 96813-5534

Email: msmp.jabsom@gmail.com
Website: http://uhmsmp.org

I, ____, do hereby agree, without reservation, to participate in the Medical Student Mentorship Program at the John A. Burns School of Medicine and its activities during the period of the 2020-2021 academic year (September 1st - May 31st).

I do hereby give permission to publish, copyright, distribute, and/or display photographic images, video, and/or audio recordings taken of me and/or my guests during the period of the 2020-2021 academic year (September 1st - May 31st) for use in public education and promotional projects by the Medical Student Mentorship Program and its associates indefinitely.

I agree to uphold the Medical Student Mentorship Program's expectations and responsibilities. I agree to contact my mentor at least once per month and to have one face-to-face meeting with my mentor during the 2020-2021 academic year, as defined on MSMP's website. Should I fail to meet the stated expectations and responsibilities, I acknowledge that I may be asked to leave MSMP for the remainder of the academic year. If applicable (Oahu or Big Island students), I will not receive a refund on my fee paid upon entry into the program. I also acknowledge MSMP's right to dismiss any mentee for any breach of professionalism or failure to uphold the program's responsibilities and expectations.

In witness whereof, I have caused this waiver to be executed on this day of __________________, 2020.

Month, Day

Member Signature:____

Parent/Legal Guardian Co-signature **(for students under 18 years of age)**:___________________________

----------- Do not write below dotted line. FOR MSMP Board Member USE ONLY ----------

Date Received : _________________________

Board Member Printed Name: __________________________

Board Member Signature ________________________________