JOHNS HOPKINS UNIVERSITY SCHOOL OF MEDICINE
SIMULATION CENTER

CONSENT & NON-DISCLOSURE AGREEMENT

I, the undersigned, ________________________________, a standardized/simulated patient, for the Johns Hopkins University School of Medicine, Simulation Center, hereby voluntarily and knowingly agree to give my express consent to:

1. Authorize the professional staff and such assistants to produce videotapes.

2. Permit such photographs, motion pictures, video tapes and/or auditory recordings to be published and republished in professional journals and medical books: to be used for any other purpose which the staff member may deem fit in the interest of medical education or research; and to be used at professional meetings of any kind.

3. Further authorize the modification or retouching of such photographs, videotapes, audio tapes and the publication of information relating to my case, either separately or in connection with the publication of the photographs/images taken of me.

In addition to the above, I also agree to the following:

4. Although I have given permission to the publication of all details and phonographs concerning my case, it is understood that I will not be identified by name.

5. I understand that all information regarding the standardized patient case for which I have been trained is the confidential property of JHU-SOM or it's client(s), and I agree that I will not disclose to any third party any information about the standardized patient case or information about the students who I have seen during the examination.

6. I understand that all rights of every kind and nature (including copyrights) in and to all photographs, motion picture, videotapes and/or auditory recordings made in connection with this standardized patient case by JHU-SOM shall be and remain vested on JHU-SOM for all purposes in perpetuity.

7. I agree to have my name, address and application information (excluding medical history) available on a database to the Johns Hopkins University School of Medicine.

8. I understand that the specific protocol(s) or nature of my training/preparation as a standardized patient on behalf of the JHU-SOM is to be held secure and confidential. I agree to hold such information secure and confidential.

____ __________
Signature of Standardized Patient, Parent or Guardian Date

____ __________
Witness Date