Inova Health System

8110 Gatehouse Road
Falls Church, Va 22042

INOVA Health System 8095 Innovation Park Drive, Fairfax, VA 22031

Course Title: INOVA Female Cadaveric Pelvic Floor Anatomy and Rehabilitative Ultrasound Symposium

Date: April 17-19, 2026

Acknowledgement and Release of Liability

I hereby consent, represent, acknowledge, and agree to the following:

I represent that I am a licensed health care professional and as such I am a qualified participant in this course. I understand that, as a licensed healthcare professional, I am solely responsible for my actions in the treatment of patients and any use of material presented in The Symposium. I acknowledge and agree that The Symposium and the content therein is the intellectual property of S. Abbas Shobeiri, MD and Ramona C. Horton, DPT and is protected by copyright laws. Prior written consent of the authors is required for any use of any content from this Symposium. I agree not to copy, reproduce, transcribe, or otherwise use the content of this material for any reason without express written consent. I acknowledge that Symposium staff may take photographs of student participation during the Symposium and agree that they will have the irrevocable, worldwide right to make, copy, edit, publish, distribute, display and otherwise use and make available the images that may contain my likeness in any media without limitation.

Nature of the Dissection Lab: I understand that the cadaver dissection involves the examination and dissection of deceased human bodies for educational purposes. The procedure may include but is not limited to, anatomical exploration, identification of organs, tissues, and structures.

Risks and Discomforts: I understand that participating in the cadaver dissection class may involve exposure to blood, bodily fluids. There may also be emotional or psychological discomfort associated with the dissection process.

Confidentiality: I understand that all information obtained during the cadaver dissection class, including the identities of the cadavers, will be kept confidential and used solely for educational purposes. I agree that any photographs taken are strictly for personal education use and may NOT be published on social media, or any public platform.

Participation: understand that this course includes hands-on lab activities with intra-vaginal assessment in which I am required to participate as both the “therapist” and “patient”. If I do not wish to participate as the “patient”, I am responsible for supplying my own medical model. If I, for any reason, am unable to participate, and have not pre-arranged for a medical model, I understand that I will be allowed to observe the course but may not participate in hands-on practice. I understand that participants of all genders may be present in the room during the completion of lab activities where participants may be in a state of undress.

WAIVER AND RELEASE OF LIABILITY:

In consideration for receiving the instruction provided by The Symposium, I hereby release INOVA Health System Foundation, their owners, trustees, directors, officers, parents, subsidiaries, affiliates, agents, employees, and contractors and agree to hold them harmless from any and all liability, claims, damages, actions, and causes of action whatsoever, for loss, damages, expenses (including costs of judgments,

settlements, court costs, and attorney's fees) or injury to person or property, irrespective of how arising and however caused, including but not limited to all kinds, degrees, and extents of negligence of INOVA Health System their owners, trustees, directors, officers, parents, subsidiaries, affiliates, agents, employees, and contractors, whether directly or indirectly related to this physical therapy, rehabilitative, manual therapy, and exercise training instruction, or the facilities and equipment used in conjunction with and/or related to such instruction. For the avoidance of doubt, this liability waiver shall cover any claims or potential claims arising from or related to infection from or transmission of communicable diseases, including but not limited to COVID-19 or any other communicable disease or virus. I further agree that all my physical and medical conditions, limitations, and sensitivities are disclosed in writing below, and hereby release and hold INOVA Health System Foundation, their owners, trustees, directors, officers, parents, subsidiaries, affiliates, agents, employees, and contractors harmless from any liability, claims, damages, actions, causes of action whatsoever in any way relating to or arising from said conditions, limitations, or sensitivities. I expressly agree to abide by the terms outlined in this consent form.
I agree to abide by any and all rules, standards of conduct, and policies established by Inova Health System pertaining to the use of their facilities. I expressly agree that this Release of Liability is intended to be as broad and inclusive as permitted by the laws of the Commonwealth of Virginia, and that this Release of Liability shall be governed by and interpreted in accordance with the laws of the Commonwealth of Virginia.
By signing below, I affirm that I have read and understood the terms and conditions outlined in this Release of Liability.

I agree to abide by any and all rules, standards of conduct, and policies established by Inova Health System pertaining to the use of their facilities. I expressly agree that this Release of Liability is intended to be as broad and inclusive as permitted by the laws of the Commonwealth of Virginia, and that this Release of Liability shall be governed by and interpreted in accordance with the laws of the Commonwealth of Virginia.

I further agree that I must disclose any physical, medical conditions, limitations, and sensitivities are disclosed in writing below, and hereby release and hold INOVA Health System, their owners, agents, employees, and contractors harmless from any liability, claims, damages, actions, causes of action whatsoever in any way relating to or arising from said conditions, limitations, or sensitivities. I expressly agree to abide by the terms outlined in this consent form.

By signing below, I attest that I am a Licensed Health Care Professional and agree to be legally bound to the terms and conditions outlined in this Release of Liability.

Name (Please Print) **Date**

Signature **Date of Birth**