CONFIDENTIALITY AGREEMENT

FOR NON-EMPLOYEES
OF THE MEDICAL COLLEGE OF WISCONSIN

I (the undersigned) will participate in the Program of the Medical College of Wisconsin,

Instructions: The above Agreement will be read by the participant and signed in the presence of the Department Administrator or a person delegated by the Administrator to witness this process, prior to participation. The original Agreement must be forwarded to the Medical College Office of Human Resources where it will be kept on file. A copy may be retained by the Department Administrator. Copies will be provided to the participant and to the Medical College Office of Risk Management. The Department Administrator will either complete the Program section below, or will make sure that it is completed by the appropriate Medical College faculty or staff member.

Program:

Dates of Program: ____________________________ to ____________________________

Location of Program: ____

Medical College Faculty and Department Responsible for Program: _________________

____

Description of Program: ____

____

____