Liability Undertaking Form

Informed Consent Confirmation by Doctor/Administrator

Location
Date

I, (Dr/Administrator)_____
state that I have researched all resources regarding the components, risks, benefits and I am with full knowledge of potential adverse effects and benefits of the mRNA vaccine (hereinafter the Vaccine), manufactured by_____; and I administered the mRNA vaccine produced by the aforementioned manufacturer to Mr/Mrs/Ms/Mx _____,
the Patient, Ward or Participant (herein referred to as Participant), on this date and attest, under penalty of perjury, that I have satisfied ALL legal, Regulatory and Ethical Informed Consent requirements (including but not limited to Informed Consent as it may relate to Clinical Trial Participation) and specific manufacturer's requirements obtaining Informed Consent by having performed the following:

I have read and explained to the Participant the 2020-2021 Vaccine Information Statement for the COVID-19 vaccine and explained its risks and benefits removing any concern the Participant may have had about its safety. I have ensured that the Participant is aware that they are a volunteer subject in a clinical experimental trial and may leave at any time without sanctions; and furthermore, I have also provided an opportunity to ask questions about the vaccine verifying comprehension by the Participant.

Therefore, I am satisfied that the Participant is fully aware of the risks versus benefits and I voluntarily assume full responsibility and liability for any adverse effect that may result in the present, mid-term or long-term from either my administration of the Vaccine(s) to the Participant or the receipt of the Vaccine (s) by the person named below for whom He/She is the legal guardian ("Ward").

I agree to undertake the necessary testing to monitor the Participant's health at no expense to the Participant. The medical procedure protocol will include:

1. Baseline Data (pre-"vaccine") Health Status Verification:
   - Complete Medical Examination.
   - Extensive Laboratory Test Panel potentially including, SARS CoV-2 Antibody Test or T-Cell (Cytokine Release Assay) Test. D-Dimer / Sedimentation Rate / C - reactive protein / Troponin / CBC (Complete Blood Count) / CMP (Complete Metabolic Panel) / ECG / other tests as may be further identified as appropriate.

2. SARS CoV-2 "Vaccination" (provisional acceptance, "without prejudice").

3. Post Treatment Data (post-"vaccine") Health Status Verification:

- Examination and labs (similar to above, with modifications as required for the emerging symptom pattern):
    - Regular Timing Delay: As appropriate for individual tests / Max 14 Days post-“vaccine” injection(s)
    - Significant adverse effects occurring following the injection – immediate relevant exam/testing.

The above 3-part procedure will be repeated in relation to any subsequent further “vaccinations” taken.

The Participant and Ward may share my name, license information/Identification with other physicians or other healthcare providers and with the Participant’s physician. The same identifiers may be shared with any reporting agency/board/association as well as to AEFI or any other agency, that I have administered the immunization(s) to the Participant.

I, for myself and on behalf of each and every one of my respective heirs, executors, personal representatives and assigns, hereby assume full liability for my actions and decisions, the clinic, location, centre, business and its affiliates, subsidiaries, divisions, directors, contractors, agents and employees (collectively “Liable Parties”), for any and all claims arising out of, in connection with or in any way related to my administering the Vaccine(s) to the Participant.

Neither the Clinic or any other Parties involved in administration of this immunization, in any way form and extent, shall, at any time or to any extent whatsoever, be released from liable, responsibility or any way protected from being held accountable for any loss, injury, death or damage suffered or sustained by the Participant or any person at any time in connection with or as a result of this vaccine program or the administration of the Vaccine(s) described above.

The information of the Participant and Ward shall remain private and not used for any purpose or shared with any person other than when allowed by law.

Doctor/Administrator’s signature:	
Participant/Agent:	
Witness 1	Witness 2
Date	