



A National Association of Medical Examiner's (N.A.M.E.) accredited office
CUYAHOGA COUNTY MEDICAL EXAMINER'S OFFICE

Thomas P. Gilson, M.D.

11001 Cedar Avenue

Cleveland, Ohio 44106

CITIZENS ACADEMY APPLICATION



APPLICANT NAME: _____ DATE OF BIRTH: _____

PERMANENT (HOME) ADDRESS: _____ GENDER: M F OTH

CITY: _____ STATE: _____ ZIP CODE: _____

PHONE: _____ DRIVER'S LICENSE NO.: _____

E-MAIL (PLEASE PRINT CLEARLY): _____ SSN (LAST 4): _____

EMPLOYER: _____ SHIRT SIZE: _____

EMPLOYER ADDRESS: _____

ORGANIZATION(S) / CLUB(S) / AFFILIATION: _____

CITIZENS ACADEMY REQUIREMENTS:

AVAILABLE SLOTS ARE LIMITED TO 30 PER ACADEMY. PARTICIPANTS MUST BE CUYAHOGA COUNTY RESIDENTS, AT LEAST 21 YEARS OF AGE, HAVE NO FELONY CONVICTIONS, AND SHOW PROOF FOR FULL COVID-19 VACCINATION. ADDITIONALLY, PARTICIPANTS WILL BE SUBJECT TO A BACKGROUND CHECK.

PARTICIPANTS MUST ATTEND AT LEAST EIGHT OF THE TEN WEEKS OF CLASS TO COMPLETE THE ACADEMY.

A CONFIDENTIALITY AND WAIVER OF LIABILITY FORM MUST BE FILLED OUT AS WELL.

PLEASE ANSWER THE FOLLOWING QUESTIONS:

WHAT ARE THE MOST IMPORTANT THINGS YOU HOPE TO LEARN?

HAVE YOU EVER VISITED THE CUYAHOGA COUNTY MEDICAL EXAMINER'S OFFICE? IF YES, WHEN?

DO YOU KNOW ANYONE THAT HAS BEEN AUTOPSIED AT THE CUYAHOGA COUNTY MEDICAL EXAMINER'S OFFICE? IF SO, PLEASE EXPLAIN (NAME? DATE OF DEATH? RELATIONSHIP TO THE DECEDENT)

WHAT IS YOUR PERCEPTION OF THE CUYAHOGA COUNTY MEDICAL EXAMINER'S OFFICE?



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HAVE YOU EVER FAINTED AT THE SIGHT OF BLOOD?

DESCRIBE YOUR CHARACTER IN A COUPLE SENTENCES

HAVE YOU PREVIOUSLY APPLIED FOR OUR CITIZENS ACADEMY? IF SO, WHEN?

DO YOU KNOW ANYONE THAT HAS ATTENDED OUR CITIZENS ACADEMY? IF SO, PLEASE PROVIDE THEIR NAME.

ARE YOU APPLYING FOR THE ACADEMY BECAUSE A FRIEND/FAMILY MEMBER/SIGNIFICANT OTHER IS APPLYING? IF SO, PLEASE PROVIDE THEIR NAME. ARE YOU WILLING TO PARTICIPATE IF YOU ARE ACCEPTED AND THEY AREN'T?

HOW DID YOU HEAR ABOUT THE CUYAHOGA COUNTY MEDICAL EXAMINER'S OFFICE CITIZENS ACADEMY?

DO YOU HAVE ANY SPECIFIC QUESTIONS THAT YOU WOULD LIKE ANSWERED?



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WHY DO YOU WISH TO ATTEND THE CITIZENS ACADEMY?

CHARACTER REFERENCE & EMERGENCY CONTACTS:

REFERENCE NAME (NON-FAMILY): _____ PHONE: _____

ADDRESS: _____ E-MAIL: _____

PRIMARY EMERGENCY CONTACT: _____ PHONE: _____

ADDRESS: _____ E-MAIL: _____

RELATIONSHIP TO PARTICIPANT: _____

SECONDARY EMERGENCY CONTACT: _____ PHONE: _____

ADDRESS: _____ E-MAIL: _____

RELATIONSHIP TO PARTICIPANT: _____



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MEDICAL INFORMATION:

ALLERGIES / FOOD ALLERGIES / DIETARY NEEDS / SPECIAL HEALTH CONSIDERATIONS:

APPLICATIONS SHOULD BE FORWARDED TO:

CUYAHOGA COUNTY MEDICAL EXAMINER'S OFFICE
C/O CHRISTOPHER HARRIS
11001 CEDAR AVENUE
CLEVELAND, OH 44106

OR

CBHARRIS@CUYAHOGACOUNTY.US

PLEASE INCLUDE A PICTURE OF YOUR COVID-19 VACCINATION CARD WITH YOUR APPLICATION

REVISED 6/13/2022



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**CUYAHOGA COUNTY MEDICAL EXAMINER'S OFFICE
CITIZENS ACADEMY RELEASE, WAIVER OF LIABILITY, AND
INDEMNIFICATION AGREEMENT**

PLEASE READ CAREFULLY BEFORE MAKING A DECISION WHETHER TO SIGN.

I, _____,
in consideration of being permitted to participate in the Cuyahoga County Medical Examiner's Office Citizens Academy ("Citizens Academy"), hereby acknowledge and agree as follows:

I am aware and understand that the Cuyahoga County Medical Examiner's Office is a forensic facility and that the work being performed at the Medical Examiner's Office inherently involves a variety of actual and potential risks, which can place myself and others at risk of harm, including personal injury and even death, due to biological, chemical, and other hazards. I am also aware of and understand the sensitive nature of what I will witness as participant in the Citizens Academy, including, but not limited to, a first-hand observation of an autopsy, which is a medical procedure used to determine the cause of death.

I fully understand all risks of my participation in the Citizens Academy, including, but not limited to, those risks set forth above, and that I am voluntarily subjecting myself to these risks as a participant. I further understand that these risks and others may be caused by my own actions or inaction, the conditions existing at the time of my participation, the negligence of Cuyahoga County and its officers, directors, employees, and agents, including, but not limited to, the negligence of the Medical Examiner's Office and its officers, directors, employees, and agents, as well as the negligence of others. I also understand that there may be other risks either known, or unknown, or not foreseen at this time.

I voluntarily assume all risks, hazards, and loss, including, but not limited to, personal injury, including serious personal injury and even death, property damage, and/or other damages that I might incur as a result of or in connection with my participation in the Citizens Academy without liability by Cuyahoga County and its officers, directors, employees, and agents, including, but not limited to, the Medical Examiner's Office and its officers, directors, employees, and agents (all parties collectively referred to as the "Public Authorities").

I fully understand that my participation in any activities of the Citizens Academy is voluntary, and I freely choose to participate. I forever waive any right that I (or my personal representatives, assigns, heirs, next of kin, and/or anyone acting on my behalf) may now have or hereafter acquire to make a claim against or to sue any or all of the Public Authorities for any injuries, death, damages, or loss, and I release and forever discharge the Public Authorities from all claims, actions, causes of action, liability, or demands for damages that I (or my personal representatives, assigns, heirs, next of kin, and/or anyone acting on my behalf) may now have or hereafter acquire against any of the Public Authorities for injuries, death, damages, or other losses sustained by me arising out of my participation in the Citizens Academy.

I further agree specifically that I will indemnify, save, and hold harmless the Public Authorities from any loss, claim, liability, action, or proceeding of every kind and character that may be presented or initiated, directly or indirectly, against any of the Public Authorities as a result of my participation in the activities of the Citizens Academy.

I acknowledge that Cuyahoga County does not provide any kind of medical coverage for me, should I be injured or killed as a result of my participating in these activities.



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Furthermore, while engaged in activities of the Citizens Academy, I will make safety my primary concern, and at all times, I will use and implement proper procedures and precautionary measures, and abide by the terms of the Confidentiality and Participation Agreement.

I acknowledge that I have read and understand this two (2) page Release, Waiver of Liability, and Indemnification Agreement. I fully understand the opportunity I am being afforded as a participant in the Citizens Academy and all of the risks involved with my participation.

I am voluntarily signing this Release, Waiver of Liability, and Indemnification Agreement without reliance upon any statement made or representation that I will not be injured or damaged or that measures will be taken to reduce or eliminate the likelihood of injury to me as a participant in the Citizens Academy.

NAME OF PARTICIPANT

SIGNATURE OF PARTICIPANT

DATE: _____



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**CUYAHOGA COUNTY MEDICAL EXAMINER'S OFFICE
CITIZENS ACADEMY CONFIDENTIALITY AND PARTICIPATION AGREEMENT**

PLEASE READ CAREFULLY BEFORE MAKING A DECISION WHETHER TO SIGN.

I, _____, in consideration of being permitted to participate in the Cuyahoga County Medical Examiner's Office Citizens Academy ("Citizens Academy"), hereby acknowledge and agree as follows:

Confidentiality

I fully recognize and understand a person's right to privacy and confidentiality of personal / medical information and the extension of that right to recorded and/or electronic information in which a person is individually identified.

I have read the attached copy of Section [313.10\(A\)\(2\) of the Ohio Revised Code](#). I understand and acknowledge that this law identifies confidential information / records of the Medical Examiner's Office, including, but not limited to, medical and psychiatric records ("Confidential Information"), which is not open to inspection or copying by the public. I further understand and acknowledge that the exceptions identified in [Section 313.10\(D\) and \(E\) of the Ohio Revised Code](#) will not apply to me as a participant in the Citizens Academy.

I understand that the Medical Examiner's Office collects, stores, and/or uses Confidential Information in performing its duties, which only personnel who have been authorized by the appropriate authority are permitted to view. **I agree not to disclose any Confidential Information to any unauthorized person(s).** I understand that the unauthorized disclosure of confidential information may be punishable under the Ohio General Laws.

Participation

I understand that as a participant in the Citizens Academy, I will have an opportunity to observe firsthand a medical-legal autopsy. I understand the sensitive nature of what I will witness and that the autopsy is a medical procedure used to determine the cause of death.

I understand and recognize that the decedents being autopsied deserve the same respect and confidentiality I would wish accorded to members of my own family. I understand that the use of cell phones and other portable electronic devices is prohibited within the Autopsy Suite and agree to turn off or silence these items. I further understand that photography, audio recording, video recording, and any other form of imaging and/or recording is strictly prohibited and grounds for immediate removal from the Medical Examiner's Office. I also understand that the Medical Examiner's Office requires a quiet environment so its staff can perform their work safely and accurately. Therefore, I agree to be courteous, attentive and refrain from loud talking and joking.

I understand that I am required to wear protective equipment because of the nature of the autopsy. I agree to wear a mask (N95 recommended), protective eye equipment, a disposable apron, and disposable gloves. I acknowledge that it is my responsibility to ensure that I have, and am wearing, the appropriate protective equipment. I further understand that, for my personal safety, I should not approach closely to the autopsy table unless instructed to do so and that the Medical Examiner's Office staff will inform me of a reasonable distance to maintain. In addition, I understand that I must turn in a signed Citizens Academy Release, Waiver of Liability, and Indemnification Agreement upon arriving at the Medical Examiner's Office.

I acknowledge that I have read and fully understand this Confidentiality and Participation Agreement. I agree to all of its terms and sign the same as my own voluntary act.

NAME OF PARTICIPANT

SIGNATURE OF PARTICIPANT

DATE



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Photo/Video/Audio Release

I hereby irrevocably grant 'Cuyahoga County' the right to use my name and/or one or more portraits, pictures, photographs, video and audio recordings of me, or reproductions or derivatives of the same, in any form for education, communication, government, and or promotional purposes, including television, radio and web video broadcasting unless otherwise noted.

I understand that I am to receive no compensation; and I agree that all such portraits, pictures, photographs, video and audio recordings and any reproductions thereof, and all plates, negatives, recording tapes, digital video and digital files shall remain the property of Cuyahoga County, unless otherwise noted.

_____	_____
Signature	Date
_____	_____
Cuyahoga County Representative	Date

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