Transplant House of Cleveland
Guest (Rental) Agreement

Eligibility: Overnight lodging is available to patients, who live an hour or more outside of Cleveland, their family members, and caregivers only while the patient is undergoing treatment, evaluation, or recovery relating to a solid organ, bone marrow, stem cell transplant procedures or associated surgery pre- or post-care.

Rental Rates: Guests contribute $50 per night for studio apartments, $60 per night for one-bedroom apartments and $75 per night for two-bedroom apartments. Rate reduction is handled on an individual basis. The contribution is the guest's portion of the total expense of the apartment (approximately $160 night day).

Release of Liability and Claims: From damages, loss, or injury to self or auto: As a guest of the Transplant House of Cleveland (herein, collectively, "THoC") facility, I hereby release and discharge, for myself, my heirs, my executors, my administrators, legal representatives, and assigns, THoC, including its directors, employees, volunteers, agents, legal representatives or assigns; and all persons acting under their permission or upon their authority, **from all claims of damages, actions, and causes whatsoever in any manner arising from my stay at the THoC facility**. The foregoing shall apply to me and any minor children in my custody. I further agree that **THoC shall not be responsible for accidents or injury to me, for the loss of any personal property while residing at the THoC facility, or for any damage sustained by my automobile while residing at the THoC facility.**

Contagious Disease: I hereby represent and warrant to THoC that, to the best of my knowledge, neither the undersigned, nor anyone staying with me, has been treated for or been exposed to any contagious disease in the past 10-days.

For myself, and any of my minor children, I hereby release THoC from any and all causes of action or damages sustained as a result of developing a contagious disease while residing at the THoC facility or afterwards.

In order to protect the other patients staying at the THoC facility, I agree that, in the event that I, or anyone staying with me, is exposed to or develop any communicable diseases, we will immediately inform the manager and await their instruction, which could include, but not be limited to, finding other accommodations, or quarantining in the apartment.

Communication with Hospitals: I hereby authorize THoC to receive or communicate any necessary information concerning the patient, from or to any medical institution or personnel.

Use of Photographs and Information: Unless otherwise expressly indicated by me in writing, by signing below I further authorize THoC to produce and make use of any photographs, slides, or any information regarding the patient, my family, and myself for the purpose of publicizing the services and work of THoC and/or medical institutions, in any event without any compensation to us or retention of any ownership or other rights in such materials by us.

By signing this form, I confirm that I understand and agree that I will conform with the foregoing requirements and the House Guidelines and that, should I fail to abide by the THoC policies and guidelines, including the House Guidelines, I may be requested to move out of the accommodations provided by THoC, and upon that request, I will do so.

I hereby warrant that I am of sound mind and legal adult age and have every right to enter into this release in my own name and for my minor children.

I further warrant that I have read the foregoing release prior to its execution, and that I fully understand the contents thereof.

This agreement shall be binding upon me and my heirs, legal representatives, executors, administrators, and assigns.

Please sign and date in the appropriate spaces below to confirm your agreement with the terms and conditions above, and also acknowledge that you have received and will comply with all House Guidelines.

Each Patient, Caregiver and adult guest must sign for themselves and their minor children occupying the apartment.

PATIENT Name: Date:

Sign Name:

CAREGIVER Name: Date:

Sign Name:

NO EXCEPTIONS are to be made to this policy.