



**MOULAGE AGREEMENT
For Simulation Spaces**

As a user of the University Simulation Spaces, I understand the importance of confidentiality with respect to information concerning simulated patients, visitors, staff and students.

I agree to adhere to the following guidelines:

- I agree to make up and moulage wounds being applied and will inform the facilitator of any allergies I may have.

Allergies

Signature: _____

Printed Name: _____

Date: _____

Course: _____

- **This document will be deleted from storage after three months. Data delete sweep will take place quarterly. With that in mind, please be advised this document may be kept in storage for up to six months before deletion.**