**This form is to be completed by an authorized school representative.**

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| --- | --- | --- |
| Student’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Please Print First and Last Name | Date  Reviewed | School Representative Initials |
| 1. Immunizations: I am verifying that the information on the student’s immunization verification form has been obtained from the student’s records on file with the school. A copy of the immunization verification form will be sent to all organizations where this student will have clinical experiences. |  |  |
| 1. **Background Check:** I verify that a criminal background check, exclusion list check from Office of Inspector General (OIG) <http://exclusions.oig.hhs.gov/> and national sexual offender registry search <http://www.nsopw.gov/en-us> has been completed on this student. I am verifying that the results show no records and/or no discrepancies. This is required unless other arrangements have been made in advance with the ORGANIZATION. |  |  |
| 1. **Random Audits:** I understand the ORGANIZATIONS will conduct random audits of the above information. Failure to comply with all requirements or not have complete records on file for a student may result in termination of the clinical experience for one or all students from this school. |  |  |
| 1. I verify the above statements to be true. I have reviewed and understand all the information that has been given to the students in the Student Checklist and Orientation Manual. |  |  |

Authorized School Rep Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**A copy of this form will be provided to each applicable organization prior to the start of the student’s clinical experience.**

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| Student’s Name |  | Student’s Phone # |  |
| Student’s Email |  | School/Program |  |
| Date(s) of experience |  | Student’s Date of Birth |  |
| Student’s Emergency Contact |  | Emergency Phone # |  |