WASHINGTON STATE UNIVERSITY COLLEGE OF NURSING

STUDENT AUTHORIZATION TO RELEASE INFORMATION TO CLINICAL AGENCIES

Student Name: ______________________________ _____ ______________________________________
(PLEASE PRINT) (First) (MI) (Last)

WSU ID: ____ Date of Birth: _____________________________

I authorize Washington State University College of Nursing to release information from my education record as requested by clinical agencies in order to attempt to secure placement for clinical/practicum experiences.

I understand clinical agencies can require that I provide additional information beyond what is contained in my WSU education record.

I acknowledge there is no guarantee that I will receive a clinical placement. I understand I will not be placed at a clinical agency if I cannot meet the agency's requirements.

This authorization is valid for a period of five (5) years from the date of my signature. I understand I may revoke this authorization at any time by providing written notice to the College of Nursing.

Signature:____Date:_______________________

Approved: WSU Office of Attorney General 041714