STUDENT ACKNOWLEDGEMENT FORM

I have provided the following items for my student experience:

- Signed “I Heard/Understood” form
- Copy of my current unexpired driver’s license
- Copy of immunization record
- Copy of current PPD (TB test)

I understand that I will not report to the facility if experiencing fever, diarrhea, nausea, vomiting, or coughing. I must be 24 hours free of any of these symptoms without the use of medications such as antipyretics, antidiarrheal meds etc. which can mask or hide symptoms.

______________________________ ______________________________
Student Name (Please Print) Student Phone Number

______________________________ ______________________________
Student Signature Requested date(s) of rotation

I take responsibility for the signee above during the student experience. I understand that I am required to inform patients of this student’s participation.

____
Responsible Preceptor / Physician Name (Please Print)

____
Responsible Preceptor / Physician Signature