Columbia State
COMMUNITY COLLEGE

Health Sciences Student Release Form

www.columbiastate.edu
(931) 540-2849

1. I understand that criminal background checks are a requirement for participating in clinical courses. I understand that based upon my criminal background check, the clinical affiliate may refuse my presence at their facility. If I cannot attend a clinical site, I understand that I will not be able to meet the requirements of the course, and therefore, would be unable to meet the graduation requirements for the Radiologic Technology program. I release Columbia State Community College and its agents and employees from any and all liability in connection with any exclusion that results from information contained in a background check. I understand that refusal from one clinical affiliate means refusal for all clinical facilities.
   _____ (Initial)

2. I understand that a drug screen is a requirement for participating in clinical courses. I understand that based upon my drug screen, the clinical affiliate may refuse my presence at their facility. If I cannot attend a clinical site, I understand that I will not be able to meet the requirements of the course, and therefore, would be unable to meet the graduation requirements for the Radiologic Technology program. I release Columbia State Community College and its agents and employees from any and all liability in connection with any exclusion that results from information contained in a drug screen. I understand that refusal from one clinical affiliate means refusal for all clinical facilities.
   _____ (Initial)

3. Any hospital, clinic, or similar medical treatment facility to which I am assigned may be required by the Joint Commission on Accreditation of Healthcare Organizations' policy to conduct an annual compliance audit of five percent (5%) or a minimum of thirty (30) background investigation files. I agree that, upon request from a hospital, clinic, or similar medical treatment facility to which I am assigned, I will provide the results of my background check, drug screen, and/or health records to be used for audit purposes only. I also authorize Columbia State Community College and its agents to release such information as requested by the clinical affiliates or agencies.
   _____ (Initial)

4. Further, I understand certain facilities may need student social security numbers and birthdates to register students for clinical rotations. I authorize Columbia State Community College and its agents to release this information for clinical purposes only. I know that they are doing so with the utmost care to protect my information; however, I am aware that nothing electronic is totally safe and I absolve Columbia State and its agents from any consequence therein.
   _____ (Initial)

5. Further, I authorize Columbia State Community College to request and gather information concerning my job performance as a Radiologic Technologist from future employers. I also authorize my employer to release information requested by Columbia State Community College. I understand this is a requirement by the Committee on Accreditation for nursing as a part of the program's accreditation.
   _____ (Initial)

Columbia State Community College is obligated by contract to implement these processes to verify compliance with its affiliates for clinical participation.

_____
Print name

_____
Signature

_____
Date