MINNESOTA DEPARTMENT OF HUMAN SERVICES

Background Study Form Information

PLEASE PRINT CLEARLY!!!!

		Middle Name			Last Name iver's License # only (if applicable)	
Date of Birth (m	n/dd/yyyy) Gender (N		1 or F) <u>MN</u> Dri			
Ethnicity:			Cauca	sian	African American Hispanic/Latino	
Social S	Security # (option	onal)		Ph	one # (including area code)	
Home Address:						
City:	City:		State:		Zip:	
Other First	Names you hav	ve used				
Other Last Email Add	Names you hav ress	ve used			arrior ID #	
		ve used Date	2	W	arrior ID #	
Email Add Signature Indicate your (effective Fa DNP Master's	ress classification ll 2011): letion Option	Date	2	 Retur	arrior ID # <u>n by August 5 to</u> : the Dean of Nursing & Health Science	



WINONA STATE UNIVERSITY College of Nursing and Health Sciences

AUTHORIZATION FOR THE RELEASE OF STUDENT BACKGROUND STUDY INFORMATION

To Whom It May Concern:

I, _____

(Print your name)

_, hereby authorize

Winona State University located at:

College of Nursing &Health Sciences PO Box 5838 – 301 Stark Hall Winona MN 55987-5838 (507) 457-5122 WSU-Rochester Center 859 30th Ave SE Rochester MN 55904-4997 (507) 285-7349

to release information contained in its files (including, but not limited to reports, records and letters or copies thereof) regarding a background study performed by the Department of Human Services, or a request to the Commissioner of Health for reconsideration of a disqualification, to determine my eligibility to participate in clinical placements to fulfill the requirements of the nursing program at Winona State University. This information may be released to the following facilities:

OR

Any clinical facility affiliated with Winona State University's Department of Nursing

I understand that the University will review this information to assess whether I may be permitted to participate in a clinical placement in its nursing program.

I understand that I am not legally obligated to provide this information. If I do provide it, the data will be considered private education data under state and federal law, and released only in accordance with those laws, or with my consent. I provide this information voluntarily and understand that I may revoke this consent at any time. A photocopy of this authorization may be used in the same manner and with the same effect as the original documents. **This authorization expires one year from the date on my background study clearance.**

Student Signature

Home Address

Zip Code