



**PHLEBOTOMY CERTIFICATION COURSE
RELEASE OF INFORMATION FORM**

Full Name: _____

MACC Student ID Number: _____

Maiden/Alias Name(s): _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____

Social Security Number: _____

Date of Birth: _____

Place of Birth: _____

I authorize Moberly Area Community College to request and obtain a copy of my criminal background as provided in Section RSMo. 610.120 and make an inquiry to the Department of Social Services regarding the "Employee Disqualification List" as provided in Section RSMo. 660.315. I also authorize Moberly Area Community College to request and obtain a copy of my drug screen results, immunization records, a Division of Family Services background check regarding child abuse or neglect, and a background check with the Office of Inspector General. I also realize I must provide a criminal background check for each state in which I have lived within the past ten (10) years.

I further authorize Moberly Area Community College to provide the necessary documentation of all the above stated information to individual clinical affiliates, to verify my eligibility to participate in the clinical experience.

Signature

Date

Witness

Date