

Clinical Externship
Medical/Documentation Authorization Release Form

PLEASE SUBMIT THIS FORM PRIOR TO RETURNING ALL VOLUNTEER/CLINICAL EXTERNSHIP DOCUMENTS REQUESTED.

First Name

Middle Name

Last Name

RELEASE AUTHORIZATION (TO BE COMPLETED BY APPLICANT)

I, _____ (print name) do hereby authorize the Center for Professional Education at UT-Chattanooga to release to potential facilities the following information which I have provided to participate in the volunteer/clinical externship experience (check all that apply):

- Background Check / Clearances/Fingerprint Card
- Drug Panel Screening
- PPD (TB) Test Results
- Immunization Record
- Physician Statement of Health
- CPR/First Aid/BCLS Certification
- Other (fill in): _____

Applicant Signature:

Date: