WASHINGTON STATE
COLLEGE OF OHIO

Respiratory Therapy Program
Personal Information Release Form

The undersigned permits the ***Respiratory Therapy Program*** at **Washington State College of Ohio** to release the student's private information as required by the clinical sites. In addition to the information below, some sites ask for additional information regarding vaccines, background checks, drug screens, and TB Gold results.

Providing this personal information is required prior to the student participating in the clinical education at our sites.

Printed Name: _____

Full SS #: _____

Date of Birth: _____

Phone #: _____

WSCO Email: _____

Student ID #: _____

Address (full): _____

I work at (if applicable): _____

Signature: _____ Date: _____

Revised: June 24, 2024

SUBMIT TO DOCUMENT UPLOAD