The University of Wisconsin-Milwaukee
College of Health Sciences

AUTHORIZATION AND RELEASE FORM

The undersigned hereby authorizes the University of Wisconsin-Milwaukee (UWM) to obtain criminal records about me from any source. I also authorize UWM to provide such records to third parties for the purpose of evaluating my application for acceptance into an internship or field/clinical placement. Such third parties and the Board of Regents of the University of Wisconsin System, its agents, employees, and officers, including the University of Wisconsin-Milwaukee, are hereby released of any liability that may arise from the disclosure of such information.

I have read and understand the above authorization and release.

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Signature of Student / Date

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Print

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Major or Student Classification (such as POCT, CLS, KIN, etc.)