UNIVERSITY OF
# DETROIT MERCY
## COLLEGE OF HEALTH PROFESSIONS & MCAULEY SCHOOL OF NURSING

Appendix B

## Student Disclosure Statement

To be retained by the Educational Institution

Student Name: _____ Date of Birth: _____

Educational Institution Name: _____ Training Program: _____

1. I certify that I have not been convicted of a crime or offense that prohibits me from being granted clinical privileges in a long-term care setting as required by P.A. 27, 28 and 29 of 2006 within the applicable time period prescribed by each crime.

_____ _____
Signature of Student Date

2. I certify that I have not been the subject of an order or disposition under the Code of Criminal Procedure dealing with findings of "not guilty by reason of insanity" for any crime.

_____ _____
Signature of Student Date

3. I certify that I have not been the subject of a state or federal agency substantiated finding of patient or resident neglect, abuse or misappropriation of property or any activity that caused my nurse aide certification to be "flagged".

_____ _____
Signature of Student Date

4. I have listed below all offenses for which I have been convicted, including all terms and conditions of sentencing, parole and probation and any substantiated finding of patient or resident neglect, abuse or misappropriation of property.

_____ _____
Signature of Student Date

| Conviction/Offense | Date of Conviction/Offense | City | State | Sentence | Date of Discharge |
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5. I certify that I have reviewed the list of prohibited offenses as defined in P.A. 27, 28 and 29, and that the above list of my convictions and/or substantiated findings of patient or resident neglect, abuse or misappropriation of property (if any) is true, correct and complete to the best of my knowledge. I also understand that if the information is not accurate or complete, my clinical privileges will be withdrawn immediately. I understand that the facility or educational program denying my privileges based on information retained through a background check is provided immunity from any action brought by a Student due to the decision to remove clinical privileges.

_____ _____
Signature of Student Date

**SIGN & RETURN TO:**
Angela Hendren
hendreaj@udmercy.edu