

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/Finding	City	State	Sentence	Date of Discharge

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 I also understand that if the information is not accurate or complete, my clinical privileges will be withdrawn immediately.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