Health Care
University of Missouri Health System

University of Missouri Health Care
Mandatory Human Resource Requirements for Clinical Students

Actual Clinical Rotation Dates (mm/dd/yy) **From:**____________________**To:** ____________________

Name of Educational Institution:________________________________ **Location:** ______________

Clinical Faculty/Instructor:____

Student/Faculty Name (If Faculty, indicate "F" for Faculty and PSV with license number to indicate that Primary Source Verification of Licensure has been completed)	7 Panel Urine Drug Screen Result Date (mm/dd/yy)	Criminal Background Checks				Sam.gov	Confidentiality Agreement Signed Date (mm/dd/yy)
		Nationwide Criminal Background Check	Office of Inspector General (OIG)	Employee Disqualification List (EDL)	Caregiver Background Screen		
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2.							
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9.							
10.							
11.							
12.							

I certify that the information submitted is accurate and the documentation verifying the information is on file at the school and/or available upon request.

Authorized Representative: ____

Revised: 6/11/2015