NORTH IOWA AREA COMMUNITY COLLEGE
RELEASE FORM

APPLICANT IDENTIFICATION AND RELEASE REGARDING INVESTIGATION OF FOUNDED CHILD OR DEPENDENT ADULT ABUSE AND CRIMINAL HISTROY RECORD IDENTIFICATION:

IDENTIFICATION: (Please Print)

Name: ____
Last First Middle

____
Birth Name and/or ALL Previous Married Name(s)

____
Address City State Zip

____
Date of Birth Gender (M/F) Social Security Number

Do you have a record of founded child or dependent adult abuse of have you ever been convicted of a crime in this state or any other state? ____No ____Yes

If Yes, Please explain the nature of the incident and date of occurrence: ______________________________
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The Iowa Administrative Code has designated the Iowa Department of Human Services for the Practical Nursing, Associate Degree Nursing, and Certified Nursing Assistant students. All other NIACC health program will utilize Mercy Medical Center-North Iowa's Human Resources Department to determine clinical eligibility regardless of clinical site placement. Anonymity is maintained when using Mercy Medical Center-North Iowa's Human Resources Department.

AUTHORIZATION AND RELEASE

The undersigned acknowledges:

1. I have executed this document in conjunction with continuation in a health program at North Iowa Area Community College. (Hereinafter referred to as "NIACC")
2. I hereby authorize NIACC access to any criminal history record produced by federal, state, or local law agencies pertaining to me.
3. I agree to release NIACC and any other person, company, or other entity from any and all causes of action that otherwise might arise from supplying clinical agencies with information they may request pursuant to this release.
4. I understand that any false answers or statements, or misrepresentations by omission made by me on this form or any related document will be sufficient cause for rejection of my application or for my immediate discharge should such falsifications or misrepresentation be discovered after my Health Program class begins.
5. I understand and agree that if I am rejected for participation in a clinical experience by an affiliating agency or if I refuse to submit to the registry checks that are required by an affiliating agency, I will be unable to complete my program of study in the health program.
6. I understand that during my educational program with NIACC, it is my responsibility to report any criminal, child abuse, and adult abuse charges pending against my record. I further authorize NIACC to conduct background checks on my record at any time during my educational program, as needed.
7. I acknowledge that these criminal and abuse checks authorize clinical eligibility, not eligibility for licensure.

Applicant Signature: ______________________________ Date: ____________________