

**COLLEGE OF NURSING**

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105 Garfield Ave | P.O. Box 4004  
Eau Claire, WI 54702-4004

University of Wisconsin  
**Eau Claire**



**STUDENT RELEASE FORM**  
**for**  
**BACKGROUND INFORMATION AND HEALTH RECORD**

I hereby grant permission to the College of Nursing at the University of Wisconsin-Eau Claire to release a copy of my “Background Information Disclosure” (BID) form and any results of my background check including but not limited to the results from the Wisconsin Departments of Justice and Regulation and Licensing to any requesting clinical agency.

I also agree that I am under a continuing obligation to notify the Dean’s Office at the College of Nursing of any new or pending charges or violations of federal, state, and local laws or the campus student conduct code that occur at any future date and during my tenure as a College of Nursing student. Failure to notify the College may result in loss of good academic standing in the College and an inability to progress in the program.

I also agree to notify the Dean’s Office at the College of Nursing in the event my program extends beyond four years so the background check can be repeated.

I understand because of background check or BID findings, clinical agencies may refuse placement of students based on the findings. This may prevent progression in or completion of the program. The findings also may affect my ability to sit for RN licensure examination, good standing with licensure, and finding future employment. A criminal history is not an automatic bar to clinical agency placement, program progression, licensure examination, and/or future employment.

I grant permission to the University of Wisconsin-Eau Claire College of Nursing to release a copy of my record of immunizations and/or titers, my tuberculin test results, proof of health insurance, my CPR certification, and any additional information to any clinical agency to which I am assigned if the agency requests same in relation to my activities there as a University of Wisconsin-Eau Claire nursing student. I also agree that I am under a continuing obligation to notify the Dean’s Office at the College of Nursing of any lapses in my personal health insurance coverage.

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Student's Printed Name

\_\_\_\_\_  
UWEC ID Number

**Please submit to [CastleBranch.com](https://www.castlebranch.com).**

**Please do not return to UW-Eau Claire College of Nursing.**

1/21/2025