AUTRY
TECHNOLOGY CENTER
THE WORKFORCE CAPITAL®

STATEMENT OF UNDERSTANDING

- ☐ I have reviewed the Advanced Medical program information sheet.
- ☐ I understand that if I am not selected for an Advanced Medical program, neither the program nor the school are under any obligation to justify the selection.
- ☐ I realize that acceptance into the program is conditional pending results of the health examination (including required immunizations), background check (includes sex offender and violent offender status), drug screening and completion of enrollment requirements.
- ☐ I am aware that arrests, charges, pending charges; convictions of a felony, gross misdemeanor, misdemeanor; being judicially declared incompetent; or falsification of records are grounds for being denied the opportunity to sit for the credential examination or possibly having my credential revoked in the future. I am aware that each accrediting agency considers each case on an individual basis.
- ☐ I am aware that arrests, charges, pending charges; convictions of a felony, gross misdemeanor, misdemeanor; being judicially declared incompetent; or falsification of records are grounds for being denied the opportunity to participate in the clinical rotation component of the program. Without participation in clinicals, it will be impossible for me to fulfill the requirements for graduation.

Signature _____ Date _____

Printed Name _____

AGREEMENT TO MAINTAIN CONFIDENTIALITY OF PATIENT PROTECTED HEALTH INFORMATION WHILE PERFORMING HOSPITAL OBSERVATION FOR APPLICATION

Maintaining patient information in a confidential manner is important to all Advanced Medical programs at Autry Technology Center. As an applicant applying to these programs, it is imperative you maintain the confidentiality of all patient information you encounter while doing your hospital observation.

AGREEMENT

I understand the information I will be reviewing at an off-campus facility (or facilities) will contain information of a confidential nature. By signing this document I hereby agree to maintain the strictest confidence of the information observed/obtained and will not divulge such information to another in a manner which could or does breach the patient's right of confidentiality. **I understand that I may be withdrawn involuntarily from the selection process for program acceptance should it be determined that I have indeed breached a patient's right to have their protected health information maintained in a confidential nature.**

Signature _____ Date _____

Printed Name _____