SAINT LUKE'S COLLEGE OF HEALTH SCIENCES
CONSENT AND AGREEMENT OF REFERENCE / EMPLOYEMENT INFORMATION

AUTHORIZATION AND CONSENT TO RELEASE INFORMATION:

I,_____, hereby voluntarily consent to and authorize the sharing of information, including but not limited to, my academic performance and competencies, my clinical performance and competencies, and overall (general and specific) professional opinions and or evaluations of the undersigned Saint Luke's College of Health Sciences faculty member, or those which I have designated below for the purposes of employment. I understand that no promise or guarantee has been made regarding the results or outcome.

I understand that Saint Luke's College of Health Sciences shall not be liable for any effects or loss of employment opportunity, based on all or part of the information supplied by the undersigned faculty member, and further hold Saint Luke's College blameless.

This authorization shall be given on _____ and shall be in force until I (student) sign the revocation line below.

I hereby certify that I have read all parts of this consent and agreement and accept all terms and conditions contained herein.

_____ Date _____ Date

Signature of Student Signature of Faculty

THE FOLLOWING NAMES AND OR COMPANIES ARE DESGINATED, BY THE STUDENT, AS AUTHORIZED TO RECEIVE INFORMATION FROM THE FACULTY MEMBER, AS OUTLINED ABOVE:

_____ _____

_____ _____

_____ _____

YOU MAY CHOOSE TO WRITE IN ALL FUTURE POTENTIAL EMPLOYEES.

REVOCATION OF AUTHORIZATION AND CONSENT TO RELEASE INFORMATION

_____ _____

Signature of Student Date