

# CRIMINAL DISCLOSURE FORM

I, \_\_\_\_\_, have been made aware and  
**Print Name**

understand the ramifications of the following offenses, in regard to my enrollment and progression in a health care provide program as it relates to me:

1. felony and/or misdemeanor convictions(s),
2. guilty plea or nolo contendere to any crime which indicates that one is unfit or incompetent to practice as a health care provider or that one has deceived or defrauded the public, and/or
3. parole violation.

Before I can enroll or continue in courses with a clinical component, any crime of which I have been convicted must be disclosed to the clinical agencies, which support the clinical components of the courses(s).

Clinical agencies have the right to refuse a clinical practicum for students in their facilities. Therefore, I may be unable to successfully complete the program because clinical objectives cannot be met, and I will be dismissed from the program.

I agree to hold harmless, the clinical agencies and staff, and college and staff for any acts under the North Carolina Tort Claims Act, NC GS 143-291 *et seq.* and accept responsibility for any and all claims, loss, liability, demands, damages or any other financial demands that may be alleged or realized.

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Print Name

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Print Name