Hillsborough County
PUBLIC SCHOOLS
Preparing Students for Life

VETERINARY SCIENCE EDUCATION

JUNIOR & SENIOR CLINICAL HANDBOOK 2023-2024

REVISED May 8, 2023

HILLSBOROUGH COUNTY PUBLIC SCHOOL
HEALTH SCIENCE

Student Information for Health Science Program

Students in Veterinary Science programs work in complex, stressful situations that require critical judgment and decision-making. It is our legal and ethical obligation to affiliating agencies and the community to ensure insofar as possible that our students are safe and stable practitioners.

Many careers in Health Science require graduates to take examinations for licensure or certification. Each occupation has its own professional board, which has rules and regulations governed by law. It is the responsibility of each professional board to issue, suspend, and revoke licenses and provide disciplinary actions for infractions. Upon completion of those programs that are under a professional board, graduates must be eligible for licensure in order to secure and maintain employment.

The following information was developed using advice from affiliating facilities, credentialing agencies' guidelines, and Core Performance Standards for Admission and Progression that were developed by the Southern Council on Collegiate Education for Nursing. Our intent is to ensure that our students are safe practitioners and that our graduates will be eligible for credentialing by the appropriate board and meet the requirements of employment.

ACADEMY OF HEALTH PROFESSIONS
CLINICAL REQUIREMENT FORM

All Veterinary Science seniors will have to complete clinical rotations as part of their medical program of studies. Below are the prerequisites for our students before they go to their clinical experiences. We recommend completing the packet during the summer break.

All seniors are required to complete the following by the due date listed below. This packet accounts for *30%* of the student's medical program grade for the first nine weeks. Completed packet and all fees are due on ***Monday, September 11, 2023*****,** for an "A." The student will lose a letter grade for each day the packet and/or fees are late.

1. ***Olive green for Juniors*** **and** ***Purple scrubs for Seniors*** with the embroidered program logo are required. Uniforms are to be clean and ironed.
2. Purchase athletic shoes with closed-toe and heel. **No Crocs allowed.**
3. ***Seniors-*** All fees are the student's responsibility: $14.00 for Professional Liability Insurance, $8.00 for Student Accident Insurance, and $34 for a 12-panel drug screening for a total of $ 56.00.

   Juniors- All fees are the student's responsibility: $14.00 for Professional Liability Insurance, $11.00 for Student Accident Insurance, and $34 for a 12-panel drug screening for a total of $ 59.00.
4. Turn in Student Information Forms – Health History and Physical Exam
5. Turn in the Infectious/Communicable Disease Contact Release Form **(requires notary)**
6. Turn in the Verification of Medical and Hospitalization Insurance form
7. Sign and Return this Clinical Requirement form
8. Turn in the Medical Release form (**requires a notary**).
9. Turn in the Instructional Field Trip and media release forms.
10. Turn in the statement of confidentiality (**requires a notary**).
11. Maintain a passing grade in the medical program of study. **Excessive absences, unsatisfactory academic progress, and/or inappropriate behavior** will preclude a student from participating in clinical rotations, which will affect the overall grade.
12. **Inappropriate behavior or dress** will result in **immediate removal** from the clinical site and could lead to a failing grade for the clinical week.
13. No artificial nails and/or polish are allowed—no clear polish. Nails must be **short**.
14. Cologne or perfume is not to be worn on clinical rotations
15. Make-up must be conservative. – no false eyelashes allowed.
16. Maintain hair in a natural and appropriate color. If hair is colored or highlighted, it must look natural; roots are not to be visible. **No** fancy hair accessories are permitted. Hair must be off the collar, pulled away from the face, and **neatly** secured, so it is not a source of contamination.
17. **No facial piercings are allowed** during clinical rotations. Students may use clear piercing retainers.
18. Jewelry is **limited** to a watch with a second hand, one **small** stud earring per ear lobe, and a medical alert tag or bracelet. **No necklaces, bracelets, or rings are to be worn.**
19. Chewing gum is **not** allowed, especially at clinical sites.

20. Socks must be worn with the uniform.

21. Facial hair on males must be clean-shaven. Beards are to be neatly trimmed.
22. Tattoos must be covered at all times. They should not be visible during clinical rotations.
23. It may be the parent's responsibility to provide transportation to and from the clinical sites.
24. **Students may not drive separately to a clinical facility if a Hillsborough County School bus has been provided to transport the student**.
25. There are **no breaks during the clinical time**. A 30-minute lunch is allowed.

*All fees are subject to change

Student ID is required daily to attend clinical rotations.

Junior Tentative Clinical Dates for the 2023-2024 School Year:
January 22- January 26, 2024

Senior Tentative Clinical Dates for the 2023-2024 School Year:

October 23- October 27, 2023

January 29- February 2, 2024
April 8 – April 12, 2024

Failure to comply with ***ALL OF THE ABOVE REQUIREMENTS*** will jeopardize the student's participation in the clinical experience. It will affect the student's grade in his/her medical program of study.

All students of The Academy of Veterinary are required to complete 500 hours of lab/clinical experience. 250 hours can be accrued through land lab experience. The other 250 hours are obtained through clinical rotations and the students' community service at an animal facility. Failure to complete and turn in these hours will result in not receiving the certificate of proficiency for Veterinary Assisting (CVA).

I understand that my son/daughter will need to complete all of the above requirements, and I understand and agree to follow the clinical procedures and requirements.

_____ _____

Parent/Guardian Signature Date

_____ _____

Student Signature Date

CLINICAL PROCEDURES AND REQUIREMENTS

ABSENCES/TARDIES

Each student is responsible for notifying the instructor and school in advance if he/she is going to be absent or tardy to the clinical experience.

DRESS CODE

1.Uniforms identifying the student will be required as well as student I.D. badges
2.Uniforms are to be clean and ironed.
- White, black, or uniform color long sleeve t-shirts may be worn under the uniform top.
- Jackets and coats may be worn on the bus or car but not in the clinical setting.
- A matching scrub jacket or white sweater may be worn in the clinical setting.

3.Students **MAY NOT** go into a clinical setting without a proper uniform.
4.Come dressed for Clinicals-**NO DRESSING OR UNDRESSING ON BUS OR IN CAR.**

PROFESSIONAL GROOMING

1. Hair **MUST** be off the collar and pulled back away from the face.
2. No fancy combs or ribbons, hair wraps, or bows. 1"-2" plain hair bands are allowed.
3. Hair should be appropriate color.
4. Make-up must be conservative.
5. Nails will be worn short in length with no polish.
6. No gum chewing

PROFESSIONAL STANDARDS

A student may be referred for disciplinary action for the following reasons:

1.Violating standard safety practices in the care of patients.
2. Delaying or omitting care that is within the identified scope of practice for the chosen course of study.
3. Being found in any restricted or unauthorized area.
4. Violation of confidential information related to patients and/or medical tests.
5. Aggressive, rude behavior to any instructor, hospital or clinical staff, physician, patient, or fellow student.
6. Leaving the clinical facility without the permission of the clinical instructor.
7. No parents, friends, or family members are allowed at the facility, only for drop-off and pick-up.
8. No cell phones are to be used at the clinical sites.

The clinical agency may request that a student be withdrawn from a facility for violation of the above code.

VERIFICATION OF MEDICAL AND HOSPITALIZATION INSURANCE

I, _____ have medical and hospitalization insurance with *_____

_____

Policy #:_____Expiration Date: _____

I understand that I am responsible for expenses incurred from any incidents or accidents that may occur during the course of training.

_____ _____

Students Signature Date

_____ _____

Parental Signature Date

If student does not have medical insurance, write "No Insurance". Make sure you sign and date the form.

SB 78001

HILLSBOROUGH COUNTY PUBLIC SCHOOLS HEALTH SCIENCE

ACKNOWLEDGEMENT OF INFECTIOUS/COMMUNICABLE DISEASE CONTACT RELEASE FORM

I understand that during the course of their clinical training, _____ (Student Name) will be working with individuals, patients and/or specimens from individuals who may have a communicable or infectious disease.

_____ _____

Signature of Parents or Legal Guardian Date

_____

Relationship to student

State of Florida, County of _____

SUBSCRIBED and sworn to _____before me, a Notary Public, this _____ day of _____,

20_____.

Signature of Notary: _____ Print Name: _____

2022-2023 SCHOOL YEAR
HILLSBOROUGH COUNTY PUBLIC SCHOOLS
STUDENT ACCIDENT INSURANCE PROTECTION PROGRAM
United States Fire Insurance Company

Who Is Covered
All students of the Hillsborough County Public School's Daycare, summer and Community Based Training Programs are covered while participating in school sponsored and supervised activities. All students are also covered while traveling, directly and without interruption, to and from any school sponsored or interscholastic athletic activity and his or her home or place of residence.

Accidental Death & Dismemberment
If a covered injury results in any of the losses specified below within one year after the date of the accident, the company will pay the applicable amount.

- Full Principal Sum for loss of life ($10,000.00)
- Full Principal Sum for double dismemberment ($10,000.00)
- 50% of the Principal Sum for loss of one hand, one foot or sight of one eye ($5,000.00)
- 25% of the Principal Sum for loss of index finger and thumb of same hand ($2,500.00)

If the Principal sum is payable, no indemnity will be paid for dismemberment. In any event, the double dismemberment indemnity is the maximum amount payable under this Benefit for all losses resulting from one accident.

Maximum Medical Expense Benefit
If the Covered Person incurs eligible expenses as the result of a covered injury, the Company will pay the charges incurred for such expense within 52 weeks, beginning on the date of accident. Payment will be made for eligible expenses in excess of other applicable insurance (if any), not to exceed the Maximum Medical Expense Benefit of $25,000.00. The first such expense must be incurred within 90 days after the date of the accident. "Eligible Expenses" means charges for the usual and customary medical procedures to promote necessary healing with the following limitations:
Hospital Inpatient Room & Board, Limited to $200.00 per day
Hospital Outpatient Expense Emergency Room, Limited to $185.00 per Injury
Physicians Expense (Non-Surgical), Limited to $40.00 per Visit
Physicians Expense (Surgical), Limited to $3,750.00 per Injury
Diagnostic Imaging, Limited to $400.00 per Injury
Physiotherapy, Limited to $35.00 per Visit with a 5 Visit Maximum
Prescription Drugs, Limited to $250.00 per Injury

Exclusions and Limitations
This Plan does not cover any loss to or resulting from:

- Sickness or disease in any form, except pyogenic infections due to an accidental cut or wound.
- The use of drugs or narcotics, unless administered under the advice of a physician.
- War or any act of war, whether or not declared.
- Participation in any riot or civil commotion.
- Air travel or the use of any device or equipment for aerial navigation, except as a fare-paying passenger on a regularly scheduled commercial airline.
- Suicide or any attempt thereat or any self-inflicted injury.
- Service provided by any person or facility employed or retained by the Policyholder or member organization.
- Service provided by any member of the Insured Person's family or household.
- Dental treatment, except as the result of a covered injury.
- The repair or replacement of any artificial dental restoration.
- Expenses payable under any Workers Compensation Law or similar legislation.
- Injury sustained while riding in or on any two or three wheeled engine driven vehicle.

To Purchase Coverage
Complete the following enrollment information and send with the appropriate premium amount to United States Fire Insurance Company, Student Insurance Processing, P.O. Box 4200, Wheaton, IL. 60189.

Name of Student Enrolling _____ Date of Birth _____
Mailing Address _____
Name of Individual School _____
Please Check Appropriate Coverage:

☐ Day Care ($3.75) ☐Summer ($3.50) ☐CBT Program ($7.50)

Signature of Parent or Guardian _____ Date _____

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits application or files claim containing a false or deceptive statement may be guilty of insurance fraud. I understand and agree that if this enrollment form is accepted by the Company, coverage will begin on the date of acceptance or on the date requested by the Policyholder, subject to the payment of the required premium.
K-12 Form SNIC-HPS/2015

Health Science Education
PHYSICAL EXAMINATION

SCHOOL:	PROGRAM:

TO BE COMPLETED BY APPLICANT PRIOR TO EXAMINATION

NAME:	PHONE:	BIRTHDATE:

ADDRESS_____
No./ Street Apt. City State Zip Code

I understand that I may be asked to submit additional data.

_____
Applicant's Signature

TO BE COMPLETED BY EXAMINER

Blood Pressure:	Temp:	Pulse:	Resp. Rate:	Height	Weight

VISION SCREENING:

Right eye with glasses:	Right eye without glasses:
Left eye with glasses:	Left eye without glasses:

HEARING SCREENING:

Forced whisper at 5 feet: Pass Fail

REVIEW OF SYSTEMS: ***(+)= Positive Findings*** ***(-)= Negative Findings***

ENT		GU/Reproductive	
Respiratory		Neuro/Muscular	
Cardiovascular		Endocrine	
GI		Integumentary	

EXPLANATION OF POSITIVE FINDINGS:

Do you consider this person to be physically capable of performing the duties required in the program stated above? _____Yes _____ No
Remarks:

_____ _____
Examining Physician/Nurse Practitioner/Physician Assistant Date

_____ _____
Address Phone

IMMUNIZATIONS

RUBEOLA AND RUBELLA

Please provide proof of immunity by one of the following means (shot record, titers or current vaccinations):

Shot record documentation

Rubeola (Measles): 2 doses live vaccine administered on or after first birthday Date: _____ Date: _____

MMR evidence of 2 doses administered on or after 1st birthday Date: _____ Date: _____

Rubella (German Measles): 1 dose live vaccine administered on or after first birthday Date: _____

Titer

Rubeola (Measles) Date: _____ Level: _____

Rubella (German Measles) Date: _____ Level: _____

If unable to document immunity through past vaccinations or through titer, please complete the following vaccinations:

Vaccinations

Rubeola* (Measles) - 2 doses at least 30 days apart Date:_____ Date: _____

Rubella* (German Measles) - 1 dose Date: _____

* **MMR may be given instead of individual immunizations.**

VARICELLA (CHICKENPOX)

History of chickenpox Yes No Date: _____

If no history of chickenpox, student must verify immune status with a titer.

Titer (required if no history of chickenpox) Date: _____

If titer is negative, 2 doses of varicella vaccine are recommended.

Vaccination (2 doses recommended) Date: _____ Date: _____

If no immunity to chickenpox, signature required.

At this time, I decline the varicella vaccinations. I understand that I do not have immunity against chickenpox and may not go into rooms with patients who have chickenpox or shingles

_____ _____

Student Signature (If Declining) Date

TETANUS	DATE:	Proof of tetanus vaccination within the past ten years must be shown through doctor's statement or "shot" record.

HEPATITIS B	Titer	DATE:	RESULTS:	
(Applicant may choose to have a titer completed. Vaccine recommended if titer does not show immunity).	Vaccine (3 doses)	DATE:	DATE:	DATE:

I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B virus (HBV) infection. However, I decline Hepatitis B Vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious and potentially life-threatening disease.

_____ _____

Student Signature (If Declining) Date

I certify that the above tests and/or vaccinations were performed in this office or have been verified from a shot or medical record

_____ _____

Examining Physician/Nurse Practitioner/Physician Assistant or Registered Nurse Date

HEALTH HISTORY

SCHOOL	PROGRAM

PLEASE COMPLETE THE FOLLOWING QUESTIONNIARE.
THE INFORMATION ON THE COMPLETED FORM WILL BE USED FOR COUNSELING PURPOSES AND WILL NOT BE USED TO DISQUALIFY ANY STUDENT FROM PROGRAM CONTINUATION.

NAME:	PHONE:	BIRTHDATE:

ADDRESS:

No./Street Apt. City State Zip Code

Have you had any serious injuries or operations within the past three years that would inhibit your ability to perform the core standards?

▫YES ▫ NO
If YES, please explain:

CHECK ANY OF THESE CONDITIONS WHICH APPLY TO YOU:

- ▫ Bone injury or other problems that prohibit lifting 40 lbs.
- Diabetes
- Hearing problems (Surgery, hearing aid, other treatment)
- Heart disease
- Problems bending frequently
- Problems pushing objects over 50 pounds
- Seizures (convulsions, epilepsy)
- Trouble standing or walking for long periods (4-6 hours)
- Vision problems (glasses, surgery, color blindness or other treatment)

Do you have any physical or mental limitations that keep you from fulfilling the requirements of the core performance standards?

▫ Yes ▫ No

If yes, please explain. _____

I have read the Student Information sheet and attest to the truth of my responses on this form. I will notify the school of any changes in my physical status.

Student signature _____ Date: _____

Hillsborough County
PUBLIC SCHOOLS
Preparing Students for Life

Student Media Release Form

Date: _____

School: _____

Student ID Number: _____

Student Name: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Dear Parent/Guardian:

Throughout the school year, the media may visit your child's school to cover special events. Hillsborough County Public Schools also may wish to interview, photograph, or videotape your child for promotional and educational reasons to utilize in publications, posters, brochures, and newsletters; on the Internet, radio, or television; or for other special district events. Before your child can participate in any of the above activities, you must give your permission by signing and returning this media release form to your child's school. Please check one of the boxes.

□ **I give my permission** for my child to be interviewed, photographed, or videotaped for use in school/district publications, school district productions, or for use on the Internet or by the general news media for print, broadcast, or on websites; and for his/her name to be published in school/district publications, on the Internet, or in news publications or broadcasts.

□ **I do not give my permission** for my child to be interviewed, photographed, or videotaped for use in school/district publications, or for use by the general news media for print, broadcast, or on websites; nor for his/her name to be published in school/district publications, on the Internet, or in news publications or broadcasts.

Parent/Guardian signature: _____

Parent/Guardian name (*please print*):_____

Date: _____

STATEMENT OF CONFIDENTIALITY

The undersigned hereby acknowledges his/her responsibility under federal and other applicable law, the agreement to keep confidential any information regarding clinical facility patients, as well as all confidential information of the clinical facility. Under penalty of law, the undersigned agrees not to reveal to any person or persons, except authorized clinical staff and associated personnel any specific information regarding any patient and further agrees not to reveal to any third party any confidential information of the clinical facility.

_____ _____

Student Name Student Signature

_____ _____

Parent/Guardian's Signature Date

(Notary Stamp)

State of Florida, County of _____ SUBSCRIBED and

sworn to _____ before me, a Notary Public, this _____ day of _____, 20_____.

Signature of Notary : _____ Print Name:

_____

Hillsborough County
PUBLIC SCHOOLS
Preparing Students for Life

FIELD TRIP MEDICAL RELEASE FORM

This form is used for recording parental permission for medical and/or surgical treatment in case of medical concerns on a field trip. **A notarized signature is required for an overnight or out-of-state field trip.**

Student Name: _____ School: _____

Date of Birth: _____ Student #: _____

Location of Field Trip: _____ Date(s) of Field Trip: _____

As the parent and/or legal guardian of (*print student name*): _____, I authorize Hillsborough County Public Schools, its agents, employees, and other officers to procure and consent to any medical emergency treatment, including hospital care, to be rendered to my child by or under the supervision of a licensed health care provider. The parent/legal guardian is responsible for any fees or costs. My signature below represents consent and agreement to the matters stated above.

_____ _____
Parent/Guardian Signature *Date*

STATE OF FLORIDA, COUNTY OF _____

SUBSCRIBED and sworn to before me, a Notary Public, this _____ day of _____, 20___.

Signature of Notary: _____ Print Name: _____

Medical Insurance Company:_____ Policy #:_____

Student's Address:_____ Phone:_____

Father's Name:_____ Phone (Day):_____

Business Name (if applicable):_____ Phone (Evening):_____

Mother's Name:_____ Phone (Day):_____

Business Name (if applicable):_____ Phone (Evening):_____

Family Physician's Name:_____ Phone:_____

Physician Address (street, city, state):_____

Check any health conditions that apply (if none, leave blank). Allergies __ Asthma __ Diabetes __ Seizures __

Heart condition __ Other (please describe):_____

Medications prescribed:_____

Hospital preference:_____

NOTE: In the event of an emergency medical situation, the chaperone/teacher will call 911 and all attempts will be made to contact the student's parent/guardian regarding the emergency.

Distribution: Office, Teacher to take original on field trip
SB 77506 (Rev. 4/24/14) BMT 5/20/14

School District of Hillsborough County
APPLICATION FOR PARTICIPATION
Instructional Field Trips

This form is used for recording student requests to participate in instructional field trips and the parent or guardian's permission for them to participate and travel in specified transportation. It must be on file before a student may participate.

Student Request

I, _____, am a student in _____class at _____ School.
Print Name of Student Print Name of Class Print Name of School

My parent/guardian's name is: _____
Print Name of Parent/Guardian

My home address is: _____
Print Street Address City State Zip

The intent of this voluntary statement is to form an agreement in which I pledge my compliance with the policies specified in the School District of Hillsborough County Student Handbook and to conduct myself on all field trips in such a manner as to bring honor to my school and myself in return for the privilege of being included as a participant in field trip activities.

_____ _____
Student Signature Date of Signature

Parent/Guardian Request

As parent or guardian, I request that _____ participate in the field trip to
Print Name of Student

_____ that will be conducted on _____.
Print Name of Trip Destination Month/Day/Year

I understand that transportation for the trip will be provided by

- A private automobile of a parent, teacher, and/or licensed student, none of which is under control of the School District of Hillsborough County
  AND/OR
- A regular school bus operated by the School District of Hillsborough County.
  AND/OR
- A private bus under charter to the School District of Hillsborough County.

_____ _____
Signature of Parent or Guardian Date of Signature

A copy of this form must be turned in to the office three (3) days prior to the field trip.

Student/ Parent Clinical

Congratulations on your acceptance into the Academy of Veterinary Science program. We have worked hard to establish our medical magnet as a high-quality place of learning and experience. We are proud of our accomplishments and know that you and your family will contribute to our continued success. The privilege of being a student in this prestigious program comes with certain responsibilities and understandings. In attending this magnet school, you have agreed to conduct yourselves in the following manner.

Student will:

- Be aware of, abide by, and follow all school, bus, and clinical site rules, routines, and procedures
- Arrive to classes on time every day prepared with necessary supplies, books, and materials.
- Attendance at all assigned clinical rotations is **mandatory**.
- Complete all classwork and homework assignments.
- Follow the uniform requirements and dress code. The clinical uniform will be worn every Tuesday and Thursday starting September 13, 2022, and Monday through Friday of each clinical week. Uniforms are to be clean, neat, and ironed.
- Students will notify their instructor immediately if absent during the clinical week, and parents must still notify the school. Failure to do so will result in a grade of zero for the day.
- Arrive at the front of the school no later than 8:15 am if riding a bus to a clinical site.
- Will report to class each clinical day upon returning to school. Skipping is grounds for a referral.
- Attend six hours of clinical rotations each day if driving to the clinical site. Upon reaching the site, call the instructor immediately to report arrival.
- Understand that I **can be removed from the clinical site** and **possibly the Health Academy** for misbehavior, failure to follow the school, bus, or facility rules and regulations and/or dress code violations.
- **Store cell phones off and out of sight while on clinical rotations *(Including during lunch)***.
- Turn in the ***clinical timecard, journal, and evaluation the first Monday after the clinical week***.
- **Actively contribute to a positive, safe and cooperative school, bus, and clinical environment**.

Parents/Guardians and family members will:

- Be aware of, abide by and follow all school, bus, and clinical site rules, routines, and procedures.
- Monitor the timely completion of homework assignments and my child's grades.
- Assure students follow dress code and uniform requirements.
- Communicate with school personnel in a timely and civil manner. Absences must be reported to the school by the parent/guardian.
- Provide accurate and up-to-date contact information.

PROFESSIONAL STANDARDS

A student may be referred for disciplinary action for the following reasons:

1. Violating standard safety practices in the care of patients.

2. Delaying or omitting care that is within the identified scope of practice for the chosen course of study.

3. Performing skills without an instructor's supervision or permission.

4. Being found in any restricted or unauthorized area.

5. Violation of confidential information related to patients and/or medical tests.

6. Aggressive, rude behavior to any instructor, hospital or clinical staff, physician, patient, or fellow student.

7. Leaving the clinical facility without the permission of the clinical instructor.

8. **NO** parents, friends, or family members are allowed at the facility, only for drop off and pick-up if a bus is not available.

9. No cell phones are to be used at the clinical sites. **Using cell phones at the clinical site can be viewed as a HIPAA violation (Patient/Client Confidentiality Agreement).**

Academic Responsibilities:

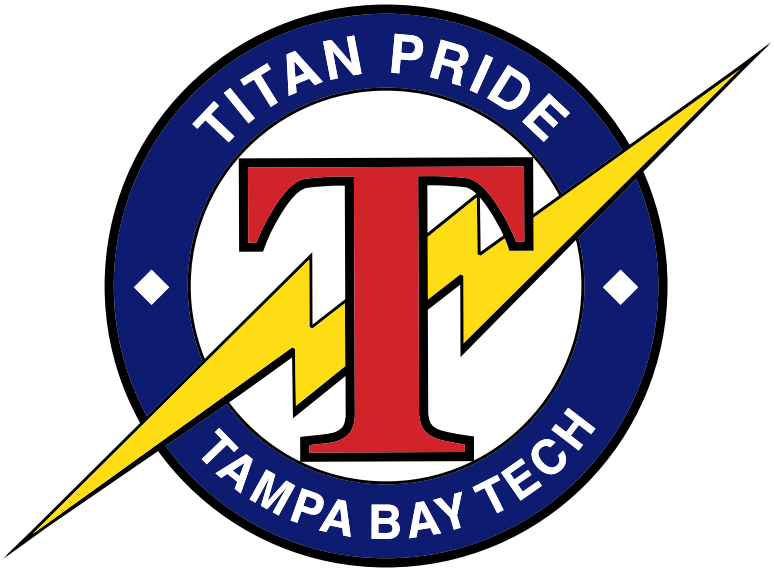
Students may be required to complete academic class assignments during clinical rotations. These assignments should be provided to the students one week prior to the clinical rotation. Students returning to school via a bus will report to the auditorium for the remainder of the school day. During this time, students should work on completing any work due upon completion of the clinical rotation.

The clinical agency may request that a student be withdrawn from a facility for violation of the above code.

_____
Student's Name Printed

_____ _____
Student Signature Date

_____ _____
Parent/Guardian Signature Date


TITAN PRIDE
TAMPA BAY TECH