

Please complete and return this form to the Graduate Programs Office in Cushing 202.  
For any questions, please call 617-552-4928 or fax 617-522-2121.

I \_\_\_\_\_  
give Boston College William F. Connell School of Nursing permission to provide copies of my immunization records, TB clearance, and general health clearance to my clinical practicum sites.

Name (please print): \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_