The University of Wisconsin-Milwaukee
College of Health Sciences

AUTHORIZATION AND RELEASE FORM

The undersigned hereby authorizes the University of Wisconsin-Milwaukee (UWM) to obtain criminal records about me from any source. I also authorize UWM to provide such records to third parties for the purpose of evaluating my application for acceptance into an internship or field/clinical placement. Such third parties and the Board of Regents of the University of Wisconsin System, its agents, employees, and officers, including the University of Wisconsin-Milwaukee, are hereby released of any liability that may arise from the disclosure of such information.

I have read and understand the above authorization and release.

__________________________________________ / Date
Signature of Student

__________________________________________
Print

__________________________________________
Major or Student Classification (such as BMS, KIN, AT, OT, CSD, etc.)