FORM B

HEALTH CARE WORKFORCE ALLIANCE of south central-southwest wisconsin

Health Care Workforce Alliance of South Central-Southwest Wisconsin
Clinical Facility Specific Orientation
Confirmation of Completion Form

I, (please print name) _____ certify that I have completed the clinical facility-specific orientation(s) as indicated below on the date(s) by my signature(s). Falsifying this statement or failure to comply with clinical agency policies will result in disciplinary action that may include expulsion from the clinical facility for the remainder of the clinical experience.

- This clinical facility specific orientation is to be completed annually per organization
- It is your responsibility to receive a unit/department specific orientation on or before your first day of clinical for each area you visit.

IMPORTANT: Please return completed form to the appropriate department at your school, NOT the healthcare facility.

_____ _____ _____

Student Name Signature Date

_____

Clinical Facility Site Name

CLINICAL FACILITY	SIGNATURE	DATE