Western University of Health Sciences

100 W. Second Street
Pomona, CA 91766-1700
Tel: (909) 706-3830 • Fax: (909) 706-3785

# AUTHORIZATION FOR RELEASE OF STUDENT HEALTH CLEARANCE DOCUMENTS

**College:** **COMP-CA** **COMP-OR** **Dental** **MSMS** **Nursing** **Optometry** **PA** **Pharmacy** **Podiatry** **PT** **Vet Med**

**Student ID # @** _____ **Grad Year 20** _____

**Please Print**

| Name | DOB | Sex: Male Female |
|---|---|---|
| Address | | Phone: |
| City/State/Zip | | |

I hereby request and authorize that the **Student-Employee Health Office** email my Health Clearance Records to my **WesternU email address** of:_____@westernu.edu or to

_____

The Health Clearance Records I am authorizing for release include:

*Immunizations/Titers *Tuberculosis Clearance Documents *History and Physical Exam

Other:_____

NOTE: Unless lined out, those with an * will be sent to the email address you indicate

**A handwritten signature is required in order to activate this request.**

Student Signature_____Date_____

Note: A photocopy or electronic scan of this document shall be as valid as an original.

**This Authorization is valid until otherwise notified in writing.**