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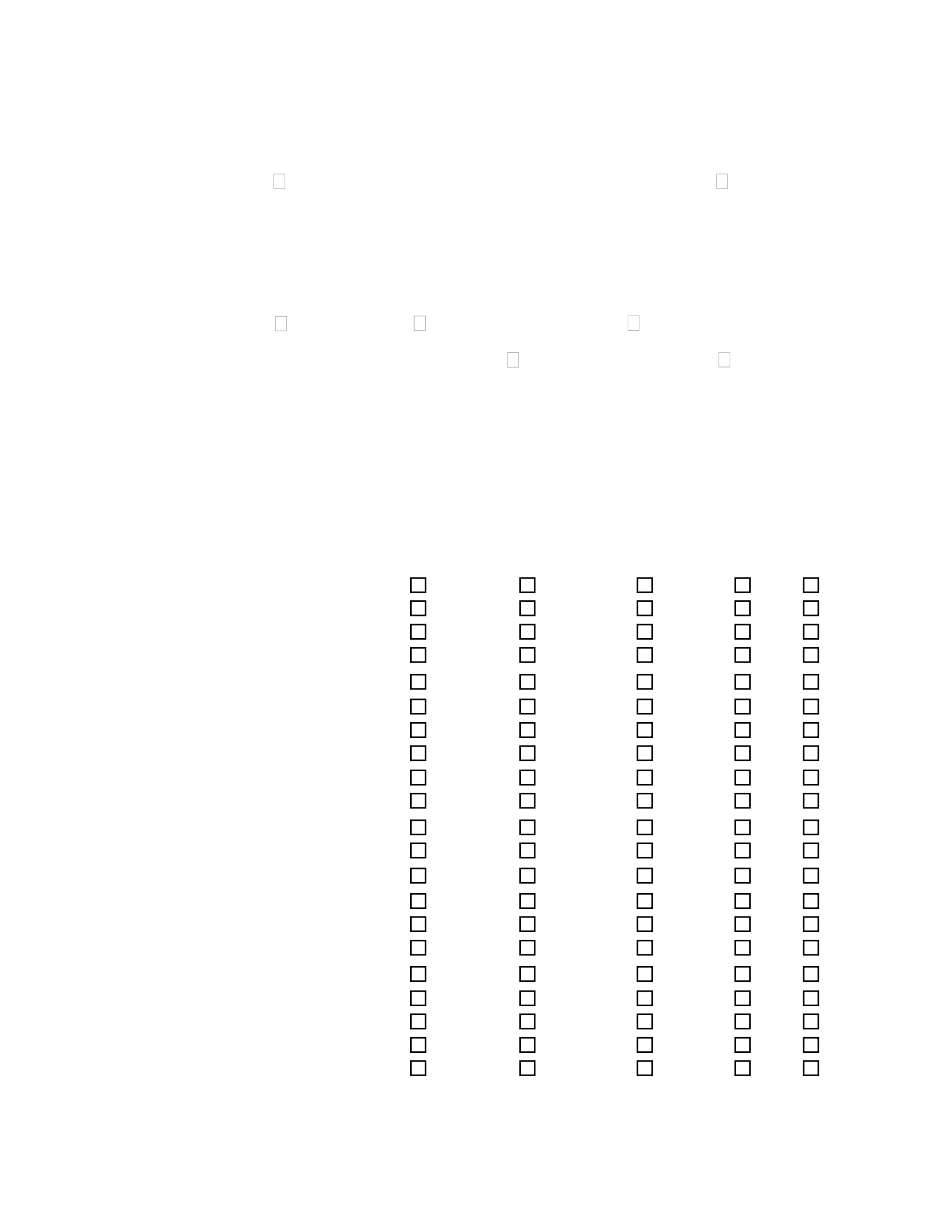

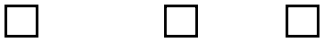

I understand that the information provided will become part of the student record subject to the Federal Family Education Rights and Privacy Act of 1974 and may be released to the student on their written request.

Healthcare Professional Signature: _____ Date: _____

Healthcare Professional Name (Print): _____

Title: _____

License or Certification #: _____

Address:

Phone: _____ Fax Number: _____

Email Address: _____