**APPENDIX B**

Clarkson College
Prepare to be the best.

**Prescribing Health Care Provider Report**

**Name (Print Patient's Full Name/Date of Birth)**: _____

List prescribed medications:

- Release by health care provider for patient to attend Clarkson College clinical experience in health care and/or other clinical agency.

**Health Care Provider's Name (printed)** : _____

**Health Care Provider's Signature**: _____

CONFIDENTIAL

Please fax form to VPAA Office
(402) 552-6058

*Filed in the Office of the VPAA*

VPAA Form 1 – Prescribing Form