## Downey Medical Center

## Safety Verification Record

KAISER PERMANENTE.
School Name
Type of Student $\square$ RN $\square$ Other $\qquad$
Instructor Name $\qquad$
Instructor Contact Information


Semester
Rotation Dates
License \# $\qquad$ Exp. Date $\qquad$
Scheduled days of week $\qquad$
Scheduled start/end times $\qquad$
Course Name and Number $\qquad$

| Last Name | First Name | AHA BLL Card <br> Exp. Date | Criminal <br> Background Check <br> Date |
| :--- | :--- | :--- | :--- |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

** Include instructor Information - including Nursing License Number on this form.
*** School is responsible for proving accuracy of this information.
Verified by (school representative): $\qquad$ Date: $\qquad$
Instructor to submit this roster before each rotation to educator of the unit along with all other student paperwork.

