KAISER PERMANENTE®

Baldwin Park Medical Center
Safety Verification Record

School Name _____
Type of Student □ RN □ Other _____

Instructor Name _____

Instructor Contact Information
Phone _____
Pager _____
Email _____

Semester _____
Rotation Dates _____

License #_____Exp. Date _____

Scheduled days of week _____
Scheduled start/end times _____
Course Name and Number _____

Last Name	First Name	AHA BLS Card Exp. Date	Criminal Background Check Date	Drug Screening Date

**** Include instructor Information - including Nursing License Number on this form.**
***** School is responsible for proving accuracy of this information.**

Verified by (school representative): _____ Date:_____

Instructor to submit this roster before each rotation to educator of the unit along with all other student paperwork.