Student Organization Clinical / Volunteer Activity Approval Form

MICHIGAN STATE UNIVERSITY COLLEGE OF OSTEOPATHIC MEDICINE

(Any activity that involves MSUCOM Students and the public with providing health information or direct patient contact)

Event Name: _____

Date: _____ **Time:** _____ **Organization:** _____

Location: _____ **Address:** _____

Name & Title of Student supplying form: _____

Supervising Physician: _____ **Contact Number:** _____

List Student Participants with class year - attach additional sheets as necessary

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Students participating in this event will perform the following clinical procedures, not to exceed the level of his/her training to date. These procedures may include:

_____ Height, Weight, BMI
_____ Blood Pressure screening
_____ Cholesterol screening
_____ Glucose screening
_____ Public health education (nutrition, exercise, cancer)
_____ Other

_____ HEENT, Heart, Lung, Vital screening
_____ Blood draw (hemoglobin, HgA1C)
_____ Flu vaccinations
_____ OMM

By my signature, I take full responsibility for the students listed to perform the noted activities under my direction.

_____ _____

Physician or COM Faculty Advisor Signature **Print Last Name** Date

FORM MUST BE TURNED IN TEN BUSINESS DAYS PRIOR TO THE EVENT

For Office Use Only

Immunization/Compliance/Eligibility Verification

Initials: _____ Date: _____