

# School of Nursing Graduate Information Guide (GIG) - Required Signature Pages

## ***GRADUATE INFORMATION GUIDE*** **(GIG)** **2025-2026**

### **A Guide for Students in**

**MASTER OF SCIENCE IN NURSING PROGRAM OPTION**

**DOCTOR OF NURSING PRACTICE PROGRAM OPTION**

### **REQUIRED SIGNATURE FORMS**

**ARKANSAS STATE UNIVERSITY  
SCHOOL OF NURSING**

**COLLEGE OF NURSING AND HEALTH PROFESSIONS**

### **Required Signature Forms**

The following attestation forms must be signed verifying that you have read and understand the stated policies or procedures. After signing each form, submit to the appropriate School of Nursing office to be placed in your permanent student file.

- ☐ Verification of Reading Graduate Information Guide (GIG)
- ☐ Verification of Receiving the Arkansas State University Handbook
- ☐ Student Confidentiality Contract
- ☐ College Code of Honor
- ☐ Permission to Provide/or Post Non-directory
- ☐ Permission to write letters of recommendation
- ☐ Disabilities Statement
- ☐ Student Criminal Background Checks
- ☐ Criminal Background Check for Initial Licensure-Nurse Practice Act 17-87-312
- ☐ Waiver of Release of Medical Information Substance Abuse Policy and Procedures
- ☐ Substance Abuse Policy and Procedures
- ☐ Substance Abuse Compliance Contract
- ☐ Hepatitis B Vaccine Declination (if applicable)
- ☐ Release and license to use image, name and voice

## **Verification of Receiving the Arkansas State University Handbook**

**VERIFICATION OF RECEIVING Arkansas State University Handbook**

**SIGNATURE PAGE**

This is to verify that I have been informed of the Arkansas State University Student Handbook.

[Student Handbook \(astate.edu\)](http://astate.edu)

I understand that I am responsible for the information contained in the University Student Handbook and that it is my responsibility to review the University Handbook each academic year for any changes.

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Student's name (please print)

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Student's signature

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Date

## Verification of Receiving Graduate Information Guide (GIG)

**VERIFICATION OF RECEIVING GRADUATE INFORMATION GUIDE (GIG)**

**SIGNATURE PAGE**

This is to verify that I have been informed of the Arkansas State University, College of Nursing and Health Profession, Graduate Information Guide (GIG) located on the CNHP School of Nursing website. I understand that I am responsible for the information contained in the *GIG* and that it is my responsibility to review the *GIG* each semester for any changes of additions and to keep the *GIG* up to date by inserting all new pages or attachments given to me by faculty of the nursing programs. <https://www.astate.edu/college/conhp/departments/nursing/word-files/GIG.pdf>

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Student's name (please print)

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Student's signature

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## Student Confidentiality Contract

## STUDENT CONFIDENTIALITY CONTRACT

The confidentiality of patients admitted to contracted clinical agencies of the School of Nursing at Arkansas State University is protect by state and federal laws as well as treatment center policy and ethical consideration. Any student who breaches confidentiality is subject to immediate termination from the clinical course. Such disclosure is also subject to applicable laws and regulations. All information regarding patients is considered confidential. This includes the following:

- A. The fact that the individual is a patient at a contracted clinical agency.
- B. The patient's name, address, and employer, etc.
- C. The nature of the patient's illness or reason for admission to the treatment center.

Students are not allowed to discuss patients with individuals in the community and are not allowed to discuss patients in patient/public areas.

I understand the information presented to me regarding patient confidentiality and acknowledge that I will assume legal responsibility for any breech I may make. I also understand that if I breach confidentiality in any way I will be immediately terminated from my clinical course at Arkansas State University.

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Student's name (please print)

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Student's signature

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Date

*\*\*\*To be signed and returned to the School of Nursing for placement in Student's File\*\*\**

## College Code of Honor

## **COLLEGE CODE OF HONOR**

Each student admitted to a professional program in the College of Nursing and health Professions is charged with the responsibility of honorable conduct. A student is assumed honorable until his/her actions prove otherwise. An honor offense is defined as an intentional act of lying, cheating, or stealing. Formal procedures exist for violations of the Honor Code.

As a student in a health program, it is fundamental that you act in an honorable and virtuous way so that a community of trust is established among members of the college and your clients. Honor is a practiced ideal that will positively impact your relationship with fellow students, faculty, administrators, patients, and other members of the community.

All students in this college are bound by the Honor Code and all are needed to make it work. The atmosphere of trust and integrity that is created by an honor system enables the student to know his/her word will be taken as true, to compete fairly in the classroom and to protect what is rightfully his/hers. The system functions best when all members of the college not only take responsibility for their own actions but hold their peers to the same standards.

As a student admitted to a health professions program, you must agree to live by and support the basic principles of honesty - no lying, cheating, or stealing; be accountable for your actions; and share information about honor offenses. If you are not prepared to accept these responsibilities, you should select another career choice.

I understand that, as an admitted student in any of the programs in the college, I have accepted the pledge of honesty and will be expected to meet the standards as set forward.

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Student's name (please print)

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Student's signature

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Date

## **Permission to Provide/or Post Non-Directory**

**PERMISSION TO PROVIDE/OR POST NON-DIRECTORY INFORMATION  
TO STUDENTS VIA E-MAIL**

I give permission for faculty of the School of Nursing to use E-mail to provide or exchange non-directory information such as assignments and other course related information with me during my enrollment in the nursing program. I understand that there is no guarantee of confidentiality on the Internet and it is possible for a third party to gain access to this information.

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Student's name (please print)

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Student's signature

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Email address

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Student ID Number

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Date

*\*\*\*To be signed and returned to the School of Nursing for placement in Student's File\*\*\**

## Permission to Write Letters of Recommendation

**PERMISSION TO WRITE LETTER(S) OF RECOMMENDATION TO INCLUDE NON-DIRECTORY INFORMATION**

I give permission for \_\_\_\_\_  
(Name of instructor)

to write a letter of recommendation to the following:

1. Name or Organization: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_
2. Name or Organization: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_
3. Name or Organization: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_

I grant permission for the inclusion non-directory information such as my grades, GPA, class rank, and/or student identification/social security number to be included as needed.

Other comments or information:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Student's name (please print)

\_\_\_\_\_  
Student's signature

\_\_\_\_\_  
Date

\*\*\*To be signed and returned to the School of Nursing for placement in Student's File\*\*\*

## Disabilities Statement

## DISABILITIES STATEMENT

Students with Disabilities: Access and Accommodations Services (A&AS) is responsible for the coordination and provision of support services to students with disabilities. We strive to ensure access for students with disabilities and to comply with ADA, ADAAA amendments act of 2008, Section 504 and Section 508 of Rehabilitation Act. Any A-State student with a disability may utilize services through A&AS. More information is available at:

<https://www.astate.edu/a/disability/> by calling 870-972- 3964. Any student in this program who has a disability that may prevent them from fully participating in this program without reasonable accommodation should contact Access and Accommodation Services as soon as possible so necessary accommodations can be made.

I, \_\_\_\_\_, have read the statement above and understand that I must register with Access and Accommodation Services in order to receive reasonable accommodations.

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Student's name (please print)

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Student's signature

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Date

*Make sure you have provided all required signatures.*

## Student Criminal Background Checks

## STUDENT CRIMINAL BACKGROUND CHECKS

Student name (print): \_\_\_\_\_

I understand that criminal background checks may occur as part of my professional education at ASTATE. Evidence of a previous charge or conviction of a felony/misdemeanor on my record may affect my progress in this program. While the faculty cannot realistically determine whether this will have any future impact on my ability to work in my profession, I do understand that the following issues could arise during my time as a student or as a graduate of the program.

1. Certain rotation sites could deny me access for rotation.
2. Hospitals or other health care institutions could refuse to allow me access for a clinical experience.
3. The above two issues could make it impossible for me to complete the clinical portion of my education and therefore not graduate.
4. Upon graduation, a state licensing agency could refuse to grant me a license.
5. As a licensed professional, certain health care institutions could refuse to grant me privileges.
6. There could be other, unforeseen, impacts of this incident on my ability to practice as a professional.

\_\_\_\_\_  
Student's name (please print)

\_\_\_\_\_  
Student's signature

\_\_\_\_\_  
Date

*\*\*\*To be signed and returned to the School of Nursing for placement in Student's File\*\*\**

## Criminal Background Check for Initial Licensure-Nurse Practice Act 17-87-312

**CRIMINAL BACKGROUND CHECK FOR INITIAL LICENSURE  
NURSE PRACTICE ACT §17-87-312 & ACA 17- 3-102**

This is to verify I read the Nurse Practice Act §17-87-312 Criminal background checks & ACA 17-3-102. I understand a first-time applicant for any license issued by the Arkansas State Board of Nursing will have a state and national criminal background check. I further understand that the identification of any offenses identified in this section of the Nurse Practice Act may prohibit me from obtaining a license to practice as a Licensed Practical Nurse, Registered Nurse or Advanced Practice Nurse in the state of Arkansas. Furthermore, although an appeal may be possible there are offenses that permanently disqualify an applicant from a license issued by the Arkansas State Board of Nursing.

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Student's name (please print)

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Student's signature

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Date

*\*\*\*To be signed and returned to the School of Nursing for placement in Student's File\*\*\**

## **Waiver of Release of Medical Information Substance Abuse Policy and Procedures**

**WAIVER OF RELEASE OF MEDICAL INFORMATION SUBSTANCE ABUSE  
POLICY AND PROCEDURES**

I, \_\_\_\_\_, am a professional health student at Arkansas State University and have previously received, read and understand the College of Nursing and Health Professions' *Substance Abuse Policy & Procedures*.

I hereby consent to having a sample of my body fluid collected on this \_\_\_\_\_ of 20\_\_\_\_ according to the terms set forth in the policy for the purpose of testing for identified substances at my own expense.

I understand that a positive test result will require a subsequent confirmation test. If that result remains positive, it will affect my status in the professional program. I understand that if I am taking any medications, which would adversely affect the results of the test, that I should disclose those immediately. Written medical documentation from my physician will be required by me for verification of those medication/s taken.

I authorize the release of test results related to the screening or testing of my blood/urine specimen to the Dean, College of Nursing and Health Professions at Arkansas State University, and to myself. I understand that my body fluid specimen will be sent to \_\_\_\_\_ for actual testing.

I hereby release Arkansas State University, its Board of Trustees, officers, employees, and agents from legal responsibility or liability arising from such a test, including but not limited to, the testing procedure, analysis, the accuracy of the analysis, or the disclosure of the results.

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Student's name (please print)

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Student's signature

Date

Time

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Witness' signature

Date

Time

## **Substance Abuse Policy and Procedures**

## **SUBSTANCE ABUSE COMPLIANCE CONTRACT**

I, \_\_\_\_\_, have read the Board of Trustee-approved Substance Abuse Policy & Procedures of the Arkansas State University College of Nursing and Health Professions located on the website <https://www.astate.edu/college/conhp/departments/nursing/index.dot> and agree, as a student in the professional health program, to comply with all aspects of the policy as written, including testing for substances and appropriate release of that information. Furthermore, I agree to abide by the provisions for dismissal and to follow the conditions of readmission as outlined.

\_\_\_\_\_  
Student's name (please print)

\_\_\_\_\_  
Student's signature

\_\_\_\_\_  
Date

## **Hepatitis B Vaccine Declination**

### **HEPATITIS B VACCINE DECLINATION**

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring the Hepatitis B virus (HBV) infection.

Risk of exposure is often highest during the professional training period. Therefore, the School of Nursing requires the Hepatitis B vaccine series for all nursing students. The cost of the vaccine is the responsibility of the student.

If you decline the Hepatitis B vaccinations for health or personal reasons, you must sign this form and submit it to the School of Nursing Office. If you are declining for health reasons include a note from your healthcare provider.

\_\_\_\_\_  
Student's name (please print)

\_\_\_\_\_  
Student's signature

\_\_\_\_\_  
Date

## **Release and License to use Image, Name, and Voice**

**ARKANSAS STATE UNIVERSITY  
RELEASE AND LICENSE TO USE IMAGE, NAME, AND VOICE**

I, the undersigned student, hereby grant Arkansas State University permission to use my image, name, and voice contained or displayed in any educational session which is recorded by sound, video, or other media. I understand that by participating in educational sessions which are recorded, my image, name, or voice may be captured and reproduced when the recording of the educational session is rebroadcast.

By signing this Release and License to use Image, Name, and Voice, I hereby assign, transfer, and convey all my rights, titles, and interests, including all copyrights and other intellectual property rights, contained in the recording of the educational sessions in which I participate to Arkansas State University. I further consent to the editing and reproduction of the educational session or sessions by Arkansas State University without any additional consent and without any payment for the use of my image, name, or voice.

I understand that the use of my image, name and voice will be primarily for the purposes of education or promotion of Arkansas State University. I hereby waive any right that I may have to inspect or approve the final audio, video, or media product that may contain my image, name, or voice. I understand and agree that Arkansas State University is and shall be the exclusive owner of all rights, titles, and interests, including copyrights, in any recorded educational session containing my image, name, or voice.

I certify that I am of legal age and have full authority to execute this Release and License to use Image, Name, and Voice. If I am not of age, my parent or legal guardian hereby consents on my behalf.

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Student's name (please print)

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Student's signature

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Address

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Phone Number

*\*\*\*To be signed and returned to the School of Nursing for placement in Student's File\*\*\**

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Revision #8

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