

**Statement of Understanding**  
**Phlebotomy Education Program**  
**Saint Luke's Hospital of Kansas City**

**Instructions: Read information carefully and return signed page with Application.**

I understand that this application will become inactive after one year.

I understand that I may be required to undergo a medical examination prior to enrollment, and further, that my enrollment in the program may be contingent upon the results of the medical examination. I also understand that a copy of my immunization record will be required upon acceptance of the program.

I have reviewed the Phlebotomy Essential Functions and understand that my ability to meet these requirements is necessary for successful completion of the Program and subsequent employability in the profession. My signature confirms my ability to meet these Essential Requirements.\*

I hereby certify that the foregoing answers and information are correct to the best of my knowledge and belief. I understand that misrepresentation will be considered as just cause for rejection of the application or dismissal from the program.

I waive any action against any entity, including Saint Luke's Hospital and the Saint Luke's Health System, for providing information in connection with this student application or inquiries in processing this application.

I understand that as a part of Saint Luke's normal procedure for processing student applications, an inquiry may be made which will provide applicable information governing character, general reputation, personal characteristics and mode of living. Upon written request additional information to the nature and scope of this report, if one is made, will be provided as legally required.

**Applicant Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

\*Any student who has a disability or condition that compromised his/her ability to meet the Essential Functions of this program for which he/she wishes to seek accommodation, must notify the Program Director of such in writing.

**Waiver of Access to Reference Statements**

*"I realize this waiver is not a required condition for admission to or receipt of financial or other services or benefits from the Saint Luke's Hospital Phlebotomy Education Program, and that I do have the right under PL 93-380 (The Family Educational Rights and Privacy Act of 1974) to inspect my references as held by this program if I enroll. However, I do also realize that persons giving recommendations may prefer to give references that are NOT open to the candidate's inspection and may elect not to respond. Therefore, on this date, as indicated by my signature below, I acknowledge all of the above and in accordance with said act do:*

*Hereby voluntarily waive my right of access under the Family Educational Rights and Privacy Act of 1974 to all of the confidential reference statements contained in my file by the Saint Luke's Hospital Phlebotomy Education Program."*

**Applicant Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_