



## RELEASE OF INFORMATION AUTHORIZATION FORM

FOR APPLICANT'S OF THE REGISTERED NURSE ASSISTANT AT SURGERY (RNAS-C™) EXAM

### To Whom it May Concern:

I authorize all individuals, institutions, entities of hospitals or institutions with which I have been associated and all professional liability insurers with which I have had or currently have professional liability insurance, who may have information bearing on my professional qualifications, ethical standing, competence and mental or physical health status to consult with the National Assistant At Surgery Council™, NASC™, and their staff or agents.

I consent to the inspection of records and documents that may be material to an evaluation of qualifications and my ability to carry out the duties and responsibilities of assistant at surgery, surgical assistant or first assistant. I authorize each and every individual and organization in custody of records and documentation to permit inspection and copying. I am willing to make myself available for interviews if requested.

I release from any liability, to the full extent of the law, all persons for acts performed in a reasonable manner in conjunction with investigating and evaluating my application and qualifications. I waive all legal claims against any individuals, institutions, entities of hospitals or institutions, or their agents who act in good faith and without malice in connection with the investigation of my RNAS-C exam application.

I further acknowledge that I have read and understand the foregoing Authorization and Release of Information Form. Photocopies and faxes of this document shall be as effective and binding as the original form and constitutes my authorization and request to release and any relevant information and supportive documentation regarding my professional qualifications, ethical standing, competence and mental or physical health status regarding my RNAS-C exam application.

*Print or Type the following:*

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Number: (     ) \_\_\_\_\_ Work/Cell Number: (     ) \_\_\_\_\_

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

National Assistant At Surgery Council

8547 E. Arapahoe Rd., Suite J-410 • Greenwood Village, CO 80112 • [info@nascouncil.org](mailto:info@nascouncil.org)

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*All candidates for the RNAS-C Exam must adhere to their state laws regarding the assistant at surgery role.*