

## **MEDICAL LABORATORY SCIENCE PROGRAM VERIFICATION OF POLICIES (VOP)**

### **INSTRUCTIONS:**

Read each of the following policy statements, below, for comprehension. You must complete the following:

1. Print document or view in Adobe Acrobat Reader
2. Review each policy statement with a witness
3. Sign and date (with a pen OR electronically in Adobe) the bottom
4. Scan the completed document or if in Adobe, save a copy, as VOP\_[LastName2026].
5. Email completed attachment to [mlsapps@svsu.edu](mailto:mlsapps@svsu.edu).

Only admitted students who have signed and returned the form according to instructions above will be able to begin the program at the assigned start date.

**Due date:** Program orientation.

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### **PROGRAM POLICY STATEMENTS:**

*I have read the **MLS Program Handbook** that describes the policies of the program, have taken or are currently taking at least one MLS course or equivalent, and **fully understand**:*

1. The function/job description/duties (ESSENTIAL FUNCTIONS) of the lab profession I have chosen to pursue and believe I can meet these standards:
  - Based on my existing skills and abilities or using typical corrective devices, or
  - With reasonable accommodation - **and I have contacted the Office of Accessibility Resources and Accommodations (ARA). ([Accessibility Resources & Accommodations - SVSU](#))**
2. The safety precautions associated with the on-campus laboratory and profession practice;
3. That I am **required** to have health insurance coverage for clinical placement;
4. That I am **required** to obtain HBV vaccination or notice of decline prior to the start of the MLS program;
5. That I am **required** to provide vaccination history and receive updated immunizations or notice of decline as described in the Certified Background Check Immunization Tracker section of the **MLS Program Handbook**, and complete orientation training and as required by the clinical facility;
6. The Policies and Procedures for Program application, Criteria for Program Progression, clinical site placement and Program Completion;

7. That I am **required** to submit to a background check and release this information to the clinical agency prior to placement and that based on this information and/or failure to disclose concerns at this time, I may be denied placement and hence completion of the program;
8. That I may be required to submit to drug screening at any time prior to or during my clinical fieldwork.

**Any questions that I may have had about the above requirements and policies have been answered by program faculty or by the Program Director to my satisfaction.**

Please sign in front of a Witness:

Name \_\_\_\_\_

Signed \_\_\_\_\_ Date: \_\_\_\_\_

Witness Name \_\_\_\_\_

Witness Signature \_\_\_\_\_ Date: \_\_\_\_\_