



University
of Windsor
Faculty of Nursing

CONSENT

Note: This document authorizes the University of Windsor to disclose a student's academic/student records to an outside institution.

Instructions: Student completes this form and submits to:

Attention: Associate Dean
Faculty of Nursing
University of Windsor
401 Sunset Avenue
Windsor, Ontario, Canada, N9B 3P4

Fax: (519) 973-7084

I, _____, hereby consent to the University of Windsor disclosing
(print first and last name)

my academic/student record from the Faculty of Nursing to _____ .
(print university name)

Dated as of the ____ day of _____, 20____

Signature

Last Name: _____ Given Names: _____

Student number: _____