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RELEASE FORM

I do hereby authorize the Wound, Ostomy, and Continence Nursing Certification Board, and those acting pursuant to its authority, to:

- a. Record my participation and appearance on video tape, audio tape, film, photograph or any other medium.
- b. Use my name, likeness, voice and biographical material in connection with these recordings.
- c. Exhibit or distribute such recording in whole or in part without restrictions or limitation for any educational or promotional purpose which the WOCNCB and those acting pursuant to its authority deem appropriate.

Print clearly:

Name: _____

Address: _____

Phone No.: _____

Signature: _____

Dated: _____