

SUNY Upstate Medical University
Safety Companion Completion Certificate

By signing below, I acknowledge that I have been provided education on Upstate Medical University's Patient Safety Companion Policy (Policy CM S-13 Safety for the At-Risk Patient – Use of a safety Companion). I understand that if I have any questions, I should contact my Supervisor.

Name: _____

Employee ID: _____

(Please Print)

Signature: _____

Date: _____

TRACKER CODE: LIGATURESUICIDE

Rev 8/2019