Student last name (print) ___________________________First name (print)_________________________Month and year of BIRTH DATE (NUMBERS) ______

EMAIL________________________________ (circle)Fall, Spring, Summer 20____ Program : _____________________________

HUNTER COLLEGE OF THE CITY UNIVERSITY OF NEW YORK
HUNTER-BELLEVUE SCHOOL OF NURSING

HEALTH REQUIREMENTS AND CLINICAL PRACTICE CLEARANCE

Establishment of a health record on all students entering the nursing program, Graduate and Undergraduate (Generic and RN Pathways), is required. The purpose of this health requirement and clinical practice clearance is to protect students as well as the clients with whom they will be working. It is also important to determine that the student is able to fulfill the objectives of the educational programs.

All students are required to submit proof of health insurance, malpractice insurance, and BCLS Certification. RN Pathway and Graduate students are required to submit current registration information for NY State RN license.

Please return all forms to:

Undergraduate and Graduate Students go to the office of: Donna Gill, Student Records Specialist (Room 615 W)

Both offices are at Hunter-Bellevue School of Nursing, 425 East 25th Street, New York, NY 10010-2590.

Students are to make 3 copies of all documents submitted, and are expected to have one copy available when on the clinical site ready for review if asked to produce the document by the nursing leadership.

All materials are to be submitted to the School of Nursing Prior to Registration in:

August for the Fall semester start or
November for Spring semester start.

Students will not be permitted to begin courses with Clinical components if these materials are NOT filed.

Link to Graduate Health Form

http://www.hunter.cuny.edu/nursing/repository/files/graduate-program-forms/HealthRequirementNursingFinal.pdf

Student last name (print) ____________________________First name (print)__________________________Month and year of BIRTH DATE (NUMBERS) ______

EMAIL__________________________________ (circle)Fall, Spring, Summer 20____ Program : ______________________________

Undergraduate and RN Pathway Students: Annual (Fall or Spring Semester)

1. Physical Examination
2. All Lab tests listed Immunizations and **Titers Records**
3. Additional documentation required by affiliating agencies
4. Health Insurance
5. Malpractice Insurance $1,000,000 / $3,000,000 (minimum requirement)
6. Certification by the American Heart Association Basic Cardiac Life Support for Health Care Workers/Provider
7. **RN Pathway Students**: New York State RN License and current registration
8. Child abuse, and Infection control certification: Optional, dependant on specific facility.
9. HIPPA & Background Certification.

Graduate Students: Annual (Fall or Spring) semester

1. Physical Examination
2. All Lab tests listed Immunizations and **Titers Records**
3. Additional requirements required by affiliating agencies
4. Health Insurance
5. Malpractice Insurance $1,000,000 / $3,000,000 (minimum requirement)
6. **For all Nurse Practitioners students:**
   Must have NURSE PRACTICIONER STUDENT Malpractice Insurance
7. New York State RN License and current registration
8. American Heart Association Certification Basic Cardiac Life Support for Health Care Workers/Providers
9. Child abuse, and Infection control certification: Optional, dependant on specific facility.
10. HIPPA & Background Certification.

Student last name (print) __________________________First name (print)________________________Month and year of BIRTH DATE (NUMBERS) ______

EMAIL_______________________________ (circle)Fall, Spring, Summer 20____ Program : ____________________________

When student has completed all health requirements give the student a copy of the statement below

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Present this document to your professor indicating that you have been cleared for Clinical placement

I ____understand the agency to which I am assigned may require more health data than listed above.

I hereby authorize **Hunter –Bellevue School of Nursing** to release my health clearance information and all associated documents, including laboratory reports and immunization waivers, to any health care provider, which may require it in connection with my participation in a clinical course. I also understand that it is my responsibility to update my H&P and PPD required by either the Undergraduate or Graduate Programs.

.

I have kept three (3) copies for my own records **and if requested to present to the assigned official at the clinical site.** I agree that if I become ill, have surgical procedure and/or become hospitalized, develop a condition, or have an exacerbation of a condition that limits my ability to fulfill the HBSON Program requirements, I will obtain health clearance again from a health care provider before returning to the Program.

I have brought the original of the required completed/signed documents to: _______________________________RN from the Office of Recruitment, Retention and Progression (offices room 401 or 430A)

Student Signature ____________________________________ Date __________________

Office of Recruitment, Retention and Progression ____RN

Hunter-Bellevue School of Nursing: Graduate Students
Check List of Required Documents Cover Sheet
http://www.hunter.cuny.edu/nursing/current-students/graduate-students/graduate-forms

Last Name (print)__________________________First Name________________________________Date: _______________

Cell Phone____________________________ E-mail: ______________________________ Course # ______

Note: INCOMPLETE FORMS WILL NOT BE ACCEPTED ***Date Completed***

1. **Physical Examination**
   a. **Signed by HCP** _______________
2. **Titers**
   a. **Measles** _______________
   b. **Mumps** _______________
   c. **Rubella** _______________
   d. **Varicella** _______________
3. **Immunization**
   a. **Tetanus** _______________
   b. **Hepatitis B OR**
   Signed Hep B Waiver _______________
4. **Screening**
   a. **(circle) PPD / CXR / Quantiferon**
   Gold Blood Test _______________
5. **Health Insurance** _______________
6. **Malpractice/Liability Insurance Exp. Date** _______________
7. **NYS License Exp. Date:** _______________
   http://www.op.nysed.gov/opsearches.htm
8. **Background Check** _______________
9. **BLS Exp. Date:** _______________
10. **HIPAA** _______________
11. **HCP verifies no limit to participate** _______________

Instructions:

Take the cover sheet/checklist and insert the dates next to each section. It would be helpful if you also highlighted the dates so it is easier to find the information.

Bring the completed forms to Ms. Gill (Rm 615 West), in order to be considered for a clinical placement.

SEMESTER	DUE DATE
Spring	November 15th
Summer	March 15th
Fall	May 10th

You will receive a "green" form that you need to keep and share with the faculty doing placements indicating that you have completed the necessary requirements for clinical placement.

Checked by______________________________________ **Date**_____________
Checked by___________________________________ **RN Date**_____________

Hunter-Bellevue School of Nursing Staff ONLY

Circle: FALL SPRING, SUMMER 20___ First name_______________ Last Name ____________________DOB__________

PERSONAL MEDICAL RECORD INFORMATION : *To be filled out by Student*

Student's Name (PRINT) ____

First Middle Maiden

Address : ____

EMAIL address ____

Home Phone #: ________________________________

Date of Birth: ________________________________ Sex: (circle) M F

Month/ Day/Year

Parents Name If Dependent: ____

Emergency Contact Person: ____

Above Person's Phone #: ________________________________

Above Person's Relationship to you ________________________________

PERSONAL HEALTH HISTORY (completed by student)

Childhood Illnesses

Place a check in the column marked yes after each of the childhood illnesses you have had.

	Yes		Yes		Yes
Measles		Rubella		Chicken Pox	
Mumps		Polio		Rheumatic Fever	

Others (fill in)

____

____

____

Place a check in the column marked yes after all of the conditions/problems that you currently have or had in the past.

	Yes		Yes		Yes
Cardiac disease		Hypertension		Stroke	
Diabetes		Joint Disease		TB	
Emphysema		Asthma		Bronchitis	
Cancer		Kidney Disease		Venereal disease	
Eye Problems		Hearing Problems		Thyroid disease	
Anemia		Allergies		Drug Sensitivities	
Stomach Problem		Ulcers		Bowel disease	
Hospitalizations		Headaches		Nervous condition	

Student to sign here: ____________________________ **Date**__________

PROGRAM________________FIRST NAME ______________LAST NAME________________DOB_______

HEALTH HISTORY AND PHYSICAL EXAM
Health Care Provider to Complete

PAST MEDICAL HISTORY

____

____

____

FAMILY HISTORY

____

____

____

SOCIAL HISTORY

____

____

____

____

Review of Systems: Note any history of pathology in the following system

General ____

Skin ____

Head ____

Eyes ____

Ears ____

Nose/Sinuses ____

Mouth/Throat ____

Neck ____

Breasts ____

Pulmonary ____

Cardiac ____

Gastrointestinal ____

Genitourinary ____

Musculoskeletal ____

Endocrine ____

Neuropsychiatric ____

Hematologic ____

Peripheral Vascular ____

PHYSICAL EXAM Note any current problem detected
(Health Care Provider to Complete)

General: - ____

Vital Signs:-____

Skin ____

Head/ Hair ____

Eyes ____

Ears ____

Nose ____

Mouth/Throat ____

Neck/Shoulders ____

Back/Chest/Lungs ____

Breasts ____

Heart ____

Abdomen ____

Extremities/Joints ____

Peripheral Pulses ____

Genitalia ____

Rectum ____

Neurology ____

ASSESSMENT
____

____

PLAN
____

____

REQUIRED LABORATORY TEST

To be completed by a Healthcare Provider
Revaccinations for negative titers are required.
Attach laboratory reports & Prior Vaccination History for Negative Titers

1. **Measles** (Rubeola) Titer:
Date Drawn__________(Attach Laboratory test results)
☐Positive
☐Negative Revaccination Date:_________
(If Titer is Negative or Equivocal)

2. Mumps Titer: Date Drawn_______ (Attach Laboratory test results)
☐Positive
☐Negative Revaccination Date:_________
(If Titer is Negative or Equivocal)

3. Rubella Titer: Date Drawn_______ (Attach Laboratory test results)
☐Positive
☐Negative Revaccination Date:_________
(If Titer is Negative or Equivocal)

4. Varicella Titer: Date Drawn_______(Attach Laboratory test results)
☐Positive
☐Negative Revaccination #1 Date:_______
(If Titer is Negative or Equivocal)
Revaccination #2 Date:_______

5. Diphtheria/Tetanus Toxoid (Td or TdAP) has been administered within ten (10) years?
- ☐ __Yes , Date ____________
- ☐ __No. If no, Td AP administration is required. Date: _____

6. PPD ___date ___________
☐Negative
☐Positive , if positive was x-ray done?, _______results_____________

7. Hepatitis B: **Titer:** Date Drawn______(Attach Laboratory test results)
☐Positive
☐Negative

Dates of Vaccinations: # 1____# 2____ # 3____**OR(next page)**

PROGRAM________________FIRST NAME ______________LAST NAME________________DOB______

Hepatitis B Vaccine Waiver

(If Vaccine waived, submit One Time Only)

I understand that during my clinical learning experiences I may be exposed to blood or other potentially infectious materials, and I may be at risk of acquiring hepatitis B virus (HBV) infection, a serious disease. I have been given the opportunity to be vaccinated with hepatitis B vaccine.

Please check the appropriate statement:

______ I decline hepatitis B vaccination at this time. I have been informed and understand the possible risks of acquiring hepatitis B.

______ I am currently in the process of receiving the 3-dose series of hepatitis B vaccine at 0-, 1-, and 6-month intervals. I will obtain anti-HB serologic testing 1-2 months after dose #3. Until this process is completed, I have been informed and understand that I continue to be at risk of acquiring hepatitis B.

Print Student Name ____

Students Signature ____

Date: ___________________

I have informed the above student of the risks associated with acquiring Hepatitis B.

____

Signature Health Care Provider (RN, NP,PA, MD, DO)

____________________ ____________________

Print name **Date**

Adapted from Occupational Safety & Health Administration
US. Department of Labor
Standard Number: 1910.1030 App A

** Can be waived; If a student has waived the Hepatitis B vaccination, the healthcare provider's signature indicates that the student has been advised by their healthcare provider of and understands the risks of not receiving the Hepatitis B vaccination. Female students who believe they are pregnant must provide a letter from their health care provider indicating their expected delivery date and the lab result for Anti-Hepatitis B; although Hepatitis B vaccine is not contraindicated during pregnancy, the decision to receive their vaccination should be made in consultation with one's health care provider. Students are advised that some health care/clinical agencies will not allow anyone who has not received the Hepatitis B vaccination and/or demonstrated immunity to Hepatitis B to participate in a clinical rotation at their site.*

Signature of Health Care Provider ________________________**Date** ______

Print or Type Name __________________________

Date__________________________ **Tel. No:** __________________________

Health Care Provider to Complete

Does the student have any disease or condition that would limit his or her full participation in the nursing program?

Yes ☐ **No** ☐
If yes please describe:

____

____

Health Care Provider (Nurse Practitioner, Physician Assistant or Physician) has determined that the named individual is eligible for clinical practice and agrees with the following statement:

I find him/her to be in good physical and mental health; he/she is free from any health impairment which is of potential risk to patients, personnel, students, or faculty and which might interfere with the performance of his/her nursing student responsibilities, with or without a reasonable accommodation. Habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances that may alter the individual's behavior has been considered in this evaluation. If a reasonable accommodation is required, I have identified the accommodation and the basis of the accommodation on a separate attachment.

NOTE: THIS FORM SHOULD NOT BE SIGNED UNLESS THE INDIVIDUAL IS ABLE TO PARTICIPATE FULLY IN ACTIVITIES REQUIRED BY HIS OR HER NURSING PROGRAM.

____

Health Care Provider (PRINT Name) ______________________________________

New York State License #____

Signature ______________________________ **Date:** _______________________

Address____

Telephone #: ____

Email: - ____

HUNTER COLLEGE OF THE CITY UNIVERSITY OF NEW YORK
HUNTER-BELLEVUE SCHOOL OF NURSING

CERTIFICATE OF COMPLETION

This is to certify that I:

NAME:____

Have read the HIPPA Training Handbook and that I have viewed the Video, "Keep It To Yourself". I understand the confidentiality and privacy issues involved in client care and personal client health data information sharing. As a health care professional, I am fully aware of my responsibility involving patient confidentiality and privacy.

Name (Print)____

Signature:____

Date:____

TO: Nursing Students

FROM: Kathleen M. Nokes, PhD, RN, FAAN
Director, Graduate Program

DATE: September 25, 2007

RE: Criminal Background Checks in Connection with Clinical Placements

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As you know, nursing students are required to complete clinical experiences at certain health care facilities as part of their degree program at The City University of New York. CUNY has been informed that some of these facilities will now require criminal background checks of students who participate in such clinical experiences and may refuse to accept certain students based on the results of these background checks.

We will keep you informed of any requirements that may affect CUNY nursing students for the semester beginning Spring Semester 2005. Meanwhile, please sign the statement below to confirm your receipt of this notice. Thank you.

Student's Statement

I am aware that I may have to obtain a criminal background check to comply with the rules of a health care facility to which I will be sent for an on-site clinical experience as part of the requirements of my nursing program. I understand that, depending on the results of such a criminal background check, I may not be able to complete the degree requirements for the nursing program and may have to withdraw from the program.

Student's Name: ______________________________

Student's Signature: ______________________________

College: ____

Date: ____