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

HEALTH REQUIREMENTS AND CLINICAL PRACTICE CLEARANCE
(GRADUATE STUDENTS)

All graduate students entering clinical courses are required to have up-to-date health records. The purpose of this health requirement and clinical practice clearance is to protect students as well as the patients 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.

Clinical clearance also requires students to submit proof of completion of HIPAA Privacy Training (found at HPEC website), health insurance, and American Heart Association BCLS Certification. Graduate must also submit current NY State RN Registration and NY State RN License.

A list of required documents is illustrated in the table below:

<table>
<thead>
<tr>
<th>GRADUATE STUDENTS ENTERING CLINICAL COURSES ARE REQUIRED TO SUBMIT THE FOLLOWING DOCUMENTS:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Annual history &amp; physical examination &amp; HCP Clearance (submit original HBSON's H&amp;P Forms)</td>
</tr>
<tr>
<td>2. Documentation of all listed immunizations and screenings including, but not limited to: TB screening, and actual titer lab results for MMR, Varicella and Hepatitis B surface antibody</td>
</tr>
<tr>
<td>3. Your personal health insurance card (submit copy)</td>
</tr>
<tr>
<td>4. Certification by the American Heart Association Basic Cardiac Life Support (BCLS) for Health Care Workers/Providers (submit copy)</td>
</tr>
<tr>
<td>5. Proof of HIPAA training</td>
</tr>
<tr>
<td>6. A copy of your NY State RN License and current NY State RN Registration is required.</td>
</tr>
<tr>
<td>7. Additional documentation may be required by affiliating agencies, such as drug screening &amp; Criminal background checks.</td>
</tr>
</tbody>
</table>

NOTE: Students are responsible for ensuring that all documentation remains up to date throughout each of their clinical placements.

Please upload all forms to: CASTLEBRANCH (see p. 2)

Students are expected to have one copy of the health clearance forms available when on the clinical site ready for review if asked to produce the documents by nursing leadership.

All required materials are to be submitted by:

April 20th for the Fall Semester
Nov. 20th for the Spring Semester

Students must upload forms that pertain to their health clearance prior to registering for clinical courses.

DOCUMENT VERSION NUMBERING: Always check that the version number located in the footer of this document matches the version published on the Hunter College School of Nursing website. Failure to use the most current forms may result in your submission being regarded as incomplete or late. Download the latest version at www.hunter.cuny.edu/nursing/current-students/graduate-students/health-requirements-and-clinical-clearance
Managing Clinical Compliance Requirements in CastleBranch

The School of Nursing has partnered with CastleBranch, one of the top ten background check and compliance management companies in the nation to provide you a secure account to manage your time sensitive school and clinical requirements. After you complete the order process and create your account, you can log in to your account to monitor your order status, view your results, respond to alerts, and complete your requirements.

You will return to your account by logging into www.castlebranch.com and entering your username (email used during order placement) and your secure password.

To place your order, go to:

https://portal.castlebranch.com/UV15

Two packages are available: Undergraduate and Graduate

When placing your initial order, you will be prompted to create a secure myCB account. From within myCB, you will be able to:

✓ View order results
✓ Manage requirements
✓ Complete tasks
✓ Upload documents
✓ Place additional orders

Please have ready personal identifying information needed for security purposes.

The email address you provide will become your username.

Need Help?


Contact Us: 888.914.7279 or servicedesk.cu@castlebranch.com
PERSONAL MEDICAL RECORD INFORMATION: To be filled out by Student

Student’s Name (PRINT)

First                        Middle                        Maiden

Address:

Cell Phone #:

(Area Code – Number)

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.

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>Yes</th>
<th>Yes</th>
<th>Others (fill in)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measles</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rubella</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chicken Pox</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mumps</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Polio</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rheumatic Fever</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>Yes</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac disease</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emphysema</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eye Problems</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anemia</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stomach Problem</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospitalizations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hypertension</td>
<td></td>
<td></td>
<td>Stroke</td>
</tr>
<tr>
<td>Joint Disease</td>
<td></td>
<td></td>
<td>TB</td>
</tr>
<tr>
<td>Asthma</td>
<td></td>
<td></td>
<td>Bronchitis</td>
</tr>
<tr>
<td>Kidney Disease</td>
<td></td>
<td></td>
<td>Venereal disease</td>
</tr>
<tr>
<td>Hearing Problems</td>
<td></td>
<td></td>
<td>Thyroid disease</td>
</tr>
<tr>
<td>Allergies</td>
<td></td>
<td></td>
<td>Drug Sensitivities</td>
</tr>
<tr>
<td>Ulcers</td>
<td></td>
<td></td>
<td>Bowel disease</td>
</tr>
<tr>
<td>Headaches</td>
<td></td>
<td></td>
<td>Nervous condition</td>
</tr>
</tbody>
</table>

Student to sign here: ____________________________________________

Date: ____________________________________________

Graduate – Version # 22-03
HEALTH HISTORY
(Health Care Provider to Complete)

PAST MEDICAL HISTORY


FAMILY HISTORY


SOCIAL HISTORY


Review of Systems:
General
Skin
Head
Eyes
Ears
Nose/Sinuses
Mouth/Throat
Neck
Breasts
Pulmonary
Cardiac
Gastrointestinal
Genitourinary
Musculoskeletal
Endocrine
Neuropsychiatric
Hematologic
Peripheral Vascular

Date: ______ Healthcare Provider Signature: ________________________________

Graduate – Version # 22-03
PHYSICAL EXAM (Health Care Provider to Complete)

General: ____________________________________________

Vital Signs: Ht: Wt: BP: __________________________________________

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

_________________________________________________________________

_________________________________________________________________

Healthcare Provider Signature: _______________________________________

Date: __________
Healthcare Provider Documentation of Required Titers, Vaccines and Screening Tests

- To be completed and signed by healthcare provider.
- Revaccinations for negative titers are required.
- Attach actual titer laboratory reports & vaccination history for negative titers.
- Titers must be within the last 7 years. TITERS ARE REQUIRED ONLY ONCE.

<table>
<thead>
<tr>
<th>Titers</th>
<th>Date Drawn</th>
<th>Results: Please circle:</th>
<th>Revaccination Date/s If applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measles (Rubeola) Titer</td>
<td></td>
<td>Positive, Negative, or Equivocal</td>
<td></td>
</tr>
<tr>
<td>Mumps Titer</td>
<td></td>
<td>Positive, Negative, or Equivocal</td>
<td></td>
</tr>
<tr>
<td>Rubella Titer</td>
<td></td>
<td>Positive, Negative, or Equivocal</td>
<td></td>
</tr>
<tr>
<td>Varicella Titer</td>
<td></td>
<td>Positive, Negative, or Equivocal</td>
<td></td>
</tr>
<tr>
<td>Hepatitis B Surface Antibody Titer</td>
<td></td>
<td>Positive, Negative, or Equivocal</td>
<td>Dates of Vaccinations: #1 #2 #3</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>OR Signed Waiver</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Vaccinations</th>
<th>Date Given</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Diphtheria/ Tetanus Toxoid (TD) or TDaP Administered within 10 years.</td>
<td>No, signed waiver</td>
<td>Lot # Administered by:</td>
</tr>
<tr>
<td>Influenza *</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Annual Screening</th>
<th>Date</th>
<th>Result (Please circle)</th>
<th>Follow-Up</th>
</tr>
</thead>
<tbody>
<tr>
<td>PPD or Quantiferon/Gold Blood Test Screening</td>
<td></td>
<td>Negative Positive</td>
<td>If positive, please attach chest X-ray report with physician clearance.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Negative Positive</td>
<td>Results</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Date:</td>
</tr>
</tbody>
</table>

Healthcare Provider Signature

________________________________________________________________________Date ____________________________

Print Name

________________________________________________________________________Date ____________________________

* The Hunter College School of Nursing requires documentation of:
  1. Date the influenza vaccine was given
  2. Lot #
  3. Health care provider or agency administering vaccine
Student Health Clearance Form

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?

No ☐

By signing below, the health care provider 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 that 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. If a reasonable accommodation is required, I have identified the accommodation and the basis of the accommodation on a separate attachment.

Health Care Provider (print name): __________________________________________

New York State License #: ________________________________________________

Signature: __________________________ Date: __________________________

Address: ______________________________________________________________

Telephone #: __________________________________________________________

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

Yes ☐

If yes please describe:
______________________________________________________________
______________________________________________________________

Health Care Provider (print name): __________________________________________

New York State License #: ________________________________________________

Signature: __________________________ Date: __________________________
Hepatitis B Vaccine Waiver
(If vaccine waived, submit this form one time only)

I understand that during my clinical placement 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.

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 Healthcare Provider

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.
Influenza is easily spread from person to person and those infected can be contagious before any signs of the flu are present. Young children, the elderly, and those with chronic health problems are at particular risk for complications from the flu.

I understand that if I do not receive the influenza vaccine, I am at greater risk of acquiring influenza and exposing patients, other healthcare providers, fellow students, faculty, and my family to influenza.

Please check both statements:

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

______ I will wear a mask when in the patient care areas at my clinical placement sites.*

I understand that some health care/clinical agencies may not allow students who have not received the Influenza vaccination to participate in a clinical placement at their site.

Print Student Name ____________________________

Student Signature _______________________________________________________________________

Date: __________________

* Required by New York State Department of Health.  
(New York State Department of Health Regulation: Section 2.59 of the New York State Sanitary Code, New York Codes Rules and Regulations (10 NYCRR). Effective as of the 2013-2014 influenza season.)
HUNTER COLLEGE CITY UNIVERSITY OF NEW YORK
HUNTER COLLEGE SCHOOL OF NURSING

HIPAA PRIVACY TRAINING
CERTIFICATION OF COMPLETION

Please view, “HIPAA: A Guide for Healthcare Workers” videos using the three modules below. After viewing the modules, upload your certificates of completion to CastleBranch.

NOTE: If you have completed HIPAA training from another institution, you may submit documentation of that training.

Access to this HIPAA training is managed by the Hunter College School of Nursing HPEC.

The 3 HIPAA modules can be completed online at https://www.medcomrn.com/cunyhunterbellevue/

The titles are:
41. VIDM283A-T Confidentiality: HIPAA Regulations
42. VIDM283B-T Confidentiality: How to Maintain Patient Confidentiality
43. VIDM283C-T Confidentiality: Vignettes

Student usernames are first and last name (janesmith) and password is nursing01

CERTIFICATE OF COMPLETION

Once you have successfully completed a module, you will receive a certificate of completion which can be uploaded to CastleBranch. Please upload all THREE certificates to CastleBranch.
HUNTER-BELLEVUE SCHOOL OF NURSING
CLINICAL PRACTICE CLEARANCE
and
STUDENT HANDBOOK ACKNOWLEDGEMENT

I _____________________________________ understand the agency to which I am
assigned may require more health data than listed on the Hunter-Bellevue School of Nursing
website.

I acknowledge that I have read the Hunter-Bellevue School of Nursing Student Handbook

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, who may require it in connection with my participation in a
clinical course.

I also understand that it is my responsibility to update and keep current my H&P, PPD or
Quantiferon, influenza vaccine, BCLS, NYS RN Registration, and health insurance.

I have kept three (3) copies for my own records 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.

Student Signature: __________________________ Date: ______________
Program: __________________________
**DO NOT SCAN & EMAIL THIS PAGE**

**HUNTER-BELLEVUE SCHOOL OF NURSING**  
**GRADUATE STUDENT CHECKLIST OF REQUIRED HEALTH AND CLINICAL CLEARANCE DOCUMENTS**

**TO BE FILLED OUT BY HBSON STUDENT FOR THEIR RECORDS**  
**DO NOT SUBMIT THIS FORM**

1. Physical Examination  Signed by HCP ______ Dated ______
2. Health Care Provider Health Clearance Form  Signed ______ Dated ______
3. Lab documentation of required titer (MMR, VZ, Hep B surface antibody) complete:
   a. Measles ______  
   b. Mumps ______  
   c. Rubella ______  
   d. Varicella ______  
   e. Hepatitis B surface antibody or signed Hep B waiver ______
4. Tetanus/TDaP (Type) ____________ (Date) ____________
5. Influenza ______ Date ____________ Adm’d by & Lot # info. ____________ or signed Influenza waiver ______
6. TB Screening Date ____________ (Circle) PPD / CXR / Quantiferon or T Spot
7. Name of Health Insurance (Copy of card attached) ______ Exp. Date: ____________
8. NYS RN License (Copy attached) ______
9. NYS RN Registration (Copy attached) Exp. Date: ____________
10. American Heart Association BCLS (Copy attached) Exp. Date: ____________
11. HIPAA Training: Module certificates or proof from other institution ______ Date: ____________
12. Clinical Practice Clearance Agreement & Student Handbook Acknowledgment
   Signed ______ Dated ______
13. Other ____________________________________________