Student Last Name (print) _____ First Name (print) _____ Clear

Month and Year of Birth (MM/YYYY) Month _____ / Year _____ Student ID # _____

Hunter email: _____@myhunter.cuny.edu Term (circle): ◯Fall ◯Spring ◯Summer 20___

**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, health insurance, and American Heart Association BCLS Certification. Graduate students must also submit current NY State RN Registration and NY State RN License.

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

**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 health clearance forms 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-Bellevue 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 (your **MyHunter email** provided in your initial order) and password.

## To place your order, go to:

https://portal.castlebranch.com/UV15

*Two packages are available: Undergraduate and Graduate. See package order form for pricing.*


**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**
- **Upload documents**
- **Manage requirements**
- **Place additional orders**
- **Complete tasks**

Please have ready personal identifying information needed for security purposes.

You must use your **MyHunter email** to create an account, which will be your username.

### Need Help?

**Visit https://mycb.castlebranch.com/help for more information.**

**Contact Us: 888.914.7279 or servicedesk.cu@castlebranch.com**

Student Last Name (print) _____ First Name (print) _____

Month and Year of Birth (MM/YYYY) Month _____ / Year _____ Student ID # _____

Hunter email: _____@myhunter.cuny.edu Term (circle): ◯Fall ◯Spring ◯Summer 20___

## 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.

| | 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:** _____

Graduate – Version # 23-09

Student Last Name (print) _____ First Name (print) _____

Month and Year of Birth (MM/YYYY) Month _____ / Year _____ Student ID # _____

Hunter email: _____@myhunter.cuny.edu Term (circle): ◯ Fall ◯ Spring ◯ Summer 20___

# 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:** _____

Student Last Name (print) _____ First Name (print) _____

Month and Year of Birth (MM/YYYY) Month _____ / Year _____ Student ID # _____

Hunter email: _____@myhunter.cuny.edu Term (circle): ◯ Fall ◯ Spring ◯ Summer 20___

# 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 _____

Student Last Name (print) _____ First Name (print) _____

Month and Year of Birth (MM/YYYY) Month _____ / Year _____ Student ID # _____

Hunter email: _____@myhunter.cuny.edu Term (circle): ◯ Fall ◯ Spring ◯ Summer 20___

**BASELINE TUBERCULOSIS RISK ASSESSMENT (Complete Once)**

1. Temporary or permanent residence of > one month in a country with a high TB rate. (Any country other than the United States, Canada, Australia, New Zealand, Northern and Western Europe) Y / N
2. Current or planned immunosuppression including HIV, organ transplant recipient, treatment with TNF-alpha agonist such as infliximab, etanercept, or other agents, including oral steroids >15mg/day for >one month. Y / N
3. Close contact with someone who has had infectious TB disease since the last TB test. Y / N

**Annual TB Screening Questions:**

Since your last TB screening have you experienced:

| | | | |
|---|---|---|---|
| 1. | A cough lasting longer than three weeks. | Yes | No |
| 2. | Coughing up blood/sputum/phlegm from deep inside the lungs. | Yes | No |
| 3. | Unexplained weight loss | Yes | No |
| 4. | Night sweats. | Yes | No |
| 5. | Weakness/fatigue | Yes | No |
| 6. | Loss of appetite | Yes | No |

**ASSESSMENT**

_____

_____

**PLAN**

_____

_____

**Healthcare Provider Signature:** _____

**Date:** _____

Student Last Name (print) _____ First Name (print) _____

Month and Year of Birth (MM/YYYY) Month _____ / Year _____ Student ID # _____

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# 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.**

| **Titers** | **Date Drawn** | **Results: Please circle:** | **Revaccination Date/s If applicable** |
|---|---|---|---|
| **Measles (Rubeola) Titer** | | **Positive, Negative, or Equivocal** | |
| **Mumps Titer** | | **Positive, Negative, or Equivocal** | |
| **Rubella Titer** | | **Positive, Negative, or Equivocal** | |
| **Varicella Titer** | | **Positive, Negative, or Equivocal** | |
| **Hepatitis B Surface Antibody Titer**<br><br>**Hepatitis C Antibody** | | **Positive, Negative, or Equivocal**<br><br>**Negative or Positive** | **Dates of Vaccinations: #1_____ #2 ____ #3____ OR Signed Waiver_____** |
| **Vaccinations** | **Date Given** | | |
| **Diphtheria/Tetanus Toxoid (TD) or TDaP** Administered within 10 years. | | | |
| **Influenza *** | | **No, signed waiver _____** | **Lot # Administered by:** |
| **Annual Screening** | **Date** | **Result (Please circle)** | **Follow-Up** |
| **Quantiferon Gold or T-Spot (IGRA)**<br>**Tuberculosis Blood Test Screening** | | **Negative**<br>**Positive** | **If positive, please attach chest X-ray report with physician clearance.**<br><br>**Results Date: _____** |

_____

**Healthcare Provider Signature**

_____ **Date**_____

**Print Name**

*** The Hunter-Bellevue School of Nursing requires documentation of (1) the date the influenza vaccine was given, (2) Lot #, and (3) the health care provider or agency administering the vaccine.**

Student Last Name (print) _____ First Name (print) _____

Month and Year of Birth (MM/YYYY) Month _____ / Year _____ Student ID # _____

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# 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** ☐ **Yes** ☐

If **YES**, please describe:

_____

_____

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 #:** _____

Student Last Name (print) _____ First Name (print) _____

Month and Year of Birth (MM/YYYY) Month _____ / Year _____ Student ID # _____

Hunter email: _____@myhunter.cuny.edu Term (circle): ◯ Fall ◯ Spring ◯ Summer 20___

# 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.*

Student Last Name (print) _____ First Name (print) _____

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# Influenza Vaccine Waiver

**(If vaccine waived, submit this form.)**

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 <u>both</u> 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.

Student Last Name (print) _____ First Name (print) _____

Month and Year of Birth (MM/YYYY) Month _____ / Year _____ Student ID # _____

Hunter email: _____@myhunter.cuny.edu Term (circle): ◯ Fall ◯ Spring ◯ Summer 20___

# HUNTER COLLEGE CITY UNIVERSITY OF NEW YORK
# HUNTER COLLEGE SCHOOL OF NURSING

# HIPAA PRIVACY TRAINING
# CERTIFICATION OF COMPLETION

HIPAA | NCLEX Review
https://youtu.be/Lh1TISuYI6E

New Nurse Tips – HIPAA Patient Privacy Issues in Nursing
https://youtu.be/7LRrFMHOWws

***Please review the videos above, then complete the attestation below AND upload this form to CastleBranch.***

I _____ have reviewed both required HIPAA videos.
**STUDENT'S NAME**

**Student Signature** _____ **Date** _____

**Program:** _____

Student Last Name (print) _____ First Name (print) _____

Month and Year of Birth (MM/YYYY) Month _____ / Year _____ Student ID # _____

Hunter email: _____@myhunter.cuny.edu Term (circle): ◯Fall ◯Spring ◯Summer 20___

# HUNTER-BELLEVUE SCHOOL OF NURSING

## CLINICAL PRACTICE CLEARANCE
## and
## STUDENT HANDBOOK ACKNOWLEDGEMENT

I _____understand the agency to which I am
**STUDENT'S NAME**
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** found on http://www.hunter.cuny.edu/nursing/repository/files/HBSON-Student-Handbook.pdf.

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, 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:** _____

Student Last Name (print) _____ First Name (print) _____

Month and Year of Birth (MM/YYYY) Month _____ / Year _____ Student ID # _____

Hunter email: _____@myhunter.cuny.edu Term (circle): ◯Fall ◯Spring ◯Summer 20___

# DO NOT SCAN & EMAIL THIS PAGE

**HUNTER-BELLEVUE SCHOOL OF NURSING**
**GRADUATE STUDENT CHECKLIST OF REQUIRED 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 titers (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 _____) Hepatitis C antibody _____

4. Tetanus/TDaP (Type) _____ (Date) _____

5. Influenza _____ Date _____ Adm'd by & Lot # info. _____
   or signed Influenza waiver _____

6. TB Screening Date _____ (Circle) Quantiferon or T Spot CXR (if positive ); Result:

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 certificate or proof from other institution _____ Date: _____

12. Clinical Practice Clearance Agreement & Student Handbook Acknowledgment
    Signed_____ Dated _____

13. Other _____