PROGRAM AND HEALTH REQUIREMENTS FOR BSN STUDENTS
To: All School of Nursing Students

From: Timothy M. Gaspar, PhD, RN
Dean & Professor

Date: July 15, 2016

RE: Program and Health Requirements

Congratulations on your acceptance into Cleveland State University School of Nursing. You have worked hard to prepare for your rigorous program and we are proud of your commitment to your professional program of study. Professional nurses are the most respected profession in our country. You will find that it offers challenges, rewards and an ongoing opportunity to grow in your career. The faculty, staff and administration are pleased your have selected Cleveland State University for your academic program of study. We stand ready to support your goal of program completion as you continue to your efforts as you work to achieve your goal.

Cleveland State is committed to Engaged Learning and the School of Nursing excels at endeavor. Your program of study includes experiences in the classroom, clinical skill lab, interprofessional simulation, and CSU affiliated clinical sites. You will have the opportunity to learn and provide patient care in excellent hospitals and community health agencies in the Greater Cleveland area. These experiences are vital to your learning the art and science of nursing on your pathway as a future professional nurse. With this opportunity comes a personal accountability for health requirements expected in the various health care settings.

The enclosed packet summarizes the data that all nursing students must provide before being allowed to participate in clinical experiences. The many agencies that the School of Nursing partners with to provide an outstanding learning environment for you have set these requirements for your protection as well as for the people you will encounter. Please be aware of deadlines for all information, not just now as you are beginning, but throughout your program. CSU cannot allow you into an agency if your data is not on file or is outdated/expired. Inability to complete clinical experiences can result in your not progressing through the program.

Please notify us if you have any questions or concerns about information in the packet. We look forward to providing you with an outstanding educational experience. Your commitment to your program of study will help us help you on your journey in nursing. Take care!
PROGRAM AND HEALTH REQUIREMENTS FOR STUDENTS

This packet contains information and forms which must be completed. Please adhere to the appropriate deadlines for submission of the forms to the School of Nursing:

- Traditional BSN Program (Fall, Daytime-Early Decision) – Before May 15th
- Traditional BSN Program (Fall, Daytime) – Before June 15th
- Traditional BSN Program (Spring, Evening/Weekends) – Before December 15th
- Accelerated BSN Program – Before October 30th
- RN to BSN Fall Program – Before September 30th
- RN to BSN Spring Program – Before January 30th

• **Student Handbook:**
  - Go to the School of Nursing Home page at: [www.csuohio.edu/nursing/information/information-for-current-students](http://www.csuohio.edu/nursing/information/information-for-current-students)
  - Download the Undergraduate Student Handbook and read completely
    - Print and sign the following sheets:
      - Memorandum of Understanding
      - Informed Consent

• **Program and Health Documentation Required:**
  - Ability to Perform Nursing Tasks
  - Health Examination Medical Forms with TDap Booster
  - Varicella (Chicken Pox) Titer
  - Measles Mumps Rubella (MMR) Titer
  - Tuberculin Mantoux Skin Test or Chest X-Ray Verification
  - Seasonal Influenza Vaccination
  - Hepatitis B Titer
  - Vision Screening
  - Dental Exam Form (optional but recommended)

• **Other Information Required:**
  - Health Insurance Verification
  - Automobile Information
  - Fingerprinting and Background Check Information
  - CPR Certification Information
  - Agency Confidentiality and related forms (Traditional BSN Evening/Weekends excluded)
  - Uniform – Dress Code Requirements (ABSN & Traditional BSN only)

1. Before you submit the documents indicated above- make a copy for your records.
2. Faxed documents cannot be accepted.
3. **NOTE:** The original documentation should be submitted to the School of Nursing

The CSU Health & Wellness Services Department provides medical services and immunizations students. For additional information, please see the next page.
Welcome CSU Nursing Students. We are here to help you with your medical admission requirements.

Health & Wellness Services
2112 Euclid Ave / Room 205
(Across from the Student Center)

Open Monday – Friday

We accept most insurances and self-payments.

Our Fees Are The Lowest In Town!

Physical Examinations ................. $30
TB tests (including interpretation of test) ............... $10 each
Bloodwork (Titers) and Vaccines also available

For a complete list of our services & current fees, visit us at:
https://www.csuohio.edu/student-affairs/health-wellness-services

For an appointment call:

............ 216-687-3649
Ability to Perform Nursing Tasks

Please consider carefully any physical limitations you might have. If you have a diagnosed disability that may prevent you from carrying out any of these physical expectations, please discuss your situation with the School of Nursing Undergraduate Program Director/Advisor. Students who enter the program do so with the understanding that they will be expected to meet course requirements, with or without any reasonable accommodations. Students who have a disability will be referred to the Office of Disability Services for determination of the reasonable accommodation that can be made.* Inability to carry out any of these activities while in the program may prevent completion of the program.

Students – Please place a checkmark next to the items that you are unable to perform.

_____1. Work for hours in a standing position and do frequent walking and stair climbing.

_____2. Independently lift and transfer an adult patient up to 6 inches from a stooped position; then, push or pull the adult up to 3 feet.

_____3. Independently lift and transfer an adult patient while you move from a stooped to an upright position to accomplish bed-to-chair and chair-to-bed transfers.

_____4. Physically apply up to 10 pounds of pressure to bleeding sites or in performing CPR.

_____5. Immediately respond and react to auditory instructions/requests, monitor equipment and perform auditory auscultation without auditory impediment.

_____6. Perform a clinical/laboratory experience for up to 12-hour duration, including standing for up to 4 hours straight at a time.

_____7. Perform close and distant visual activities involving objects, persons, and paperwork, as well as discriminate depth and color perception (If need accommodation, i.e. glasses or contacts, check line).

_____8. Discriminate between rough/smooth and hot/cold when using hands.

_____9. Manipulate small objects in precise movements; for example, prepare and administer injectable medications.

_____10. Communicate intelligibly, both orally and in writing.

_____11. Use products containing natural rubber latex due to allergy.

Student Statement – Please sign one of the following statements:

1. I am able to perform the unchecked tasks without accommodation.

   Student Signature _____________________________________________ Date _________________

2. I am able to perform the checked tasks only with accommodation.

   Student Signature _____________________________________________ Date _________________

If you have a disability that requires accommodation, please have your physician/nurse practitioner verify the disability.

Physician Statement

I have examined the above student and hereby verify that she or he has a physical disability (# ______ above) that will require accommodations in order to carry out activities.

Physician/Nurse Practitioner Signature _____________________________________________

Physician/Nurse Practitioner Name ________________________________  Date _______________

(Please print name) This information must be legible and include professional credentials.

* The University Office of Disability Services will determine if an accommodation is reasonable in accordance with applicable law.

To be completed by a physician/nurse practitioner. Please return to:
   School of Nursing
   2121 Euclid Avenue, JH 238
   Cleveland, OH 44115-2214
Health Examination Medical Form

A physical examination is required for all students upon admission to the Nursing Program. The student may have a physical examination performed by his/her private physician/nurse practitioner or at CSU Health & Wellness Services Department. Complete this page and give to your physician/nurse practitioner when the physical examination is done. This information will be treated confidentially.

<table>
<thead>
<tr>
<th>Last</th>
<th>First</th>
<th>M. I.</th>
<th>CSU I.D. Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Street Address:

(City)   (State)   (Zip)

( )    ( )    /    /

(Home Phone with Area Code)   (Cell Phone with Area Code)   (Date of Birth)

HEALTH HISTORY (COMPLETE BEFORE VISIT WITH PHYSICIAN/NURSE PRACTITIONER)

Have you had, or do you now have, any of the following: (Please check all YES answers.)

- Allergies
- High Blood Pressure
- Scarlet Fever
- Anemia
- Joint Pains
- Seizures
- Asthma
- Kidney Pain
- Shortness of Breath on Exertion
- Cancer
- Liver Disease
- Sickle Cell Disease/Trait
- Cold Sores (frequent)
- Migraine Headaches
- Strep Throat
- Cough (pERSISTENT)
- Mononucleosis
- Stroke
- Diabetes
- Psychological/Psychiatric Problems
- Rheumatic Fever

Do you use tobacco in any form? If yes, specify type: ______________________ Amount: ________________

Do you have any physical impairment that limits your activity?  □ No  □ Yes (If yes, please explain)

Do you have any other health or medical problems not listed?  □ No  □ Yes (If yes, please explain)

Are you presently taking any kind of medication(s)  □ No  □ Yes  (If yes, name drug(s) and how often taken)

Do you have any allergies (food, medicine, environmental)?  □ No  □ Yes (If yes, please list)

I hereby certify that I have read and understand all of the above questions, and have responded to them to the best of my knowledge. I also consent to the release of medical information to the Program and clinical site.

_____________________________________________________   ________________________
Student’s Signature          Date
<table>
<thead>
<tr>
<th>PHYSICAL EXAMINATION</th>
<th>*ABNORMAL</th>
<th>HEIGHT</th>
<th>WEIGHT</th>
<th>PULSE</th>
<th>B/P</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Appearance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**PHYSICIAN'S NOTE ON PHYSICAL & SUMMARY OF SIGNIFICANT FINDINGS**

*Abnormal finds must have documentation.

- **Skin**
- **Eyes, include Fundus**
- **Ears /Hearing**
- **Nose/Sinuses**
- **Mouth, Throat**
- **Neck, include Thyroid**
- **Chest, include Breasts**
- **Heart**
- **Vascular System**
- **Lymphatic System**
- **Abdomen, Include Inguinal**
- **Genitourinary System**
- **Nervous System**
- **Extremities**
- **Spine, Other Musculoskeletal**
- **Anus, Rectum**

**DISTANT VISION**

| Right 20/___ | Corrected to 20/___ | Glucose | Right: ☐ Passed | Left: ☐ Passed |
| Left 20/___  | Corrected to 20/___  | Protein | ☐ Failed        | ☐ Failed      |
| Both 20/___  | Corrected to 20/___  |         |                 |               |

**URINE**

- Right: ☐ Passed
- Left: ☐ Passed
- Failed

**HEARING**

- Right: ☐ Passed
- Left: ☐ Passed
- Failed

**IMMUNIZATIONS/INFECTIOUS DISEASE EVALUATION – REQUIRED**

- **Tetanus/Diphtheria** – Boosters required every 10 years. (Original Series may be DPT or Td)
  - Date of Original Series _______________________
  - Date of Last Boster _______________________
- **Tuberculin (TB) Skin Test** . . . Complete Form on Page 9
  - *TB (Mantoux Only….., 2 Step Process) NOTE: Chest x-ray required if Mantoux positive (CHEST X-RAY: Date & Results)
- **Hepatitis B** . . . Complete Form on Page 10
- **MMR (Measles, Mumps, Rubella)** . . . Complete Form on Page 10
- **Varicella** . . . Complete Form on Page 8
- **Seasonal Flu** – Required . . . By October 15th, Complete Form on Page 10

**Physician/Nurse Practitioner’s Name (Please Print)**

**Office Address**

**City, State**

**Zip Code**

This information must be legible and include professional credentials.

**Examining Physician or Nurse Practitioner Signature**

**Date**

**Phone # including area code**

*Place Physician’s Office Stamp in the Box on the Right for Validation*:

*An Official Letter from the Physician/Nurse Practitioner detailing the above may be substituted for a validation stamp.*
**IMMUNIZATION STATUS** – Students must provide documentation of satisfactory immunization status for the following:

a. **Tetanus-Diphtheria Toxoid** - Most students will have completed their original DPT (Diphtheria, Pertussis or "Whooping Cough" and Tetanus) series during their childhood. If the student was older than six years, the primary immunization series required three injections of TD. The date of completion of either series and the date of a TD (Tetanus-Diphtheria) booster within the past ten years must be recorded on the **Health Examination Form**. Please indicate number of immunizations received in the series and dates of the boosters. If the student is due for a TD booster at this time, he/she should have it **administered at least two month prior to classes**, with the scheduled date of the immunization noted on the form.

b. **MMR (Measles, Mumps, Rubella)** – Students must show proof of a **positive titer**. If titer is negative, student must be re-immunized and retested with blood titer results showing immunity recorded on the **Measles, Mumps, Rubella Form**.

   Rubella also known as German Measles
   Rubeola also known as English Measles

c. **Varicella** - Students are required to submit proof from a physician or health institution of having a positive titer. If titer is negative, student must be re-immunized and retested with result recorded on the **Verification of Having Varicella (Chicken Pox) Illness, Immunization, and Blood Titer Test Form**.

d. **TB Mantoux Test** - The two-step TB Mantoux Test or QuantiFERON report is required for all students admitted to the Nursing Program and a one-step or QuantiFERON is required for every subsequent year in the program. A physician will determine the appropriate follow-up for positive results. The **results of the TB Mantoux Test or Chest X-Ray should be indicated on the TB Mantoux Skin Test or Chest X-Ray Form**.

   The PPD and/or Chest X-Ray can be administered by your private physician or at the County Tuberculosis Clinic located on the ground floor of the Bell Greve Building at Cleveland MetroHealth Medical Center. The telephone number is (216) 778 - 8305. An appointment is required. The PPD is also available at the CSU Health & Wellness Services Department.

e. **Hepatitis B** – The School of Nursing requires that all nursing students receive the Hepatitis B Vaccine. This is to be administered as a series of three. The date of each dose is to be recorded on the **Verification of Completed Hepatitis B Immunization Form** and submitted after each injection. Documentation of a positive titer is required to show immunity. The vaccine is also available at the CSU Health & Wellness Services Department.

f. **Seasonal Influenza (Flu Shot) Vaccination** - The Centers for Disease Control established the requirement that anyone working in any health care setting must receive a Flu Shot every year. Documentation must be recorded on the **Seasonal Influenza (Flu Shot) Vaccination Form** and submitted by October 15th **ANNUALLY** to be qualified to continue or begin clinical.

To be completed by physician or nurse. Please return to:

School of Nursing
2121 Euclid Avenue, JH 238
Cleveland, OH 44115-2214
HEPATITIS B IMMUNIZATION

Have you completed a series of Hepatitis B immunization?

1. If so, have a titer drawn and complete the following:

<table>
<thead>
<tr>
<th>Titer Result:</th>
<th>Physician/Nurse Practitioner Name &amp; Credentials (Please Print):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive</td>
<td></td>
</tr>
<tr>
<td>Negative</td>
<td></td>
</tr>
</tbody>
</table>

(Date of Titer) (Physician/Nurse Practitioner Signature) Place Physician’s Stamp in the Above Box for Validation*

If your results are positive, you are done!

2. If not, one full series of re-immunization is required followed by a second titer to confirm immunization.

<table>
<thead>
<tr>
<th>1st Vaccination Date</th>
<th>Physician/Nurse Practitioner Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Place Physician’s Stamp in this Box for Validation*</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2nd Vaccination Date</th>
<th>Physician/Nurse Practitioner Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Place Physician’s Stamp in this Box For Validation*</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3rd Vaccination Date</th>
<th>Physician/Nurse Practitioner Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Place Physician’s Stamp in this Box For Validation*</td>
<td></td>
</tr>
</tbody>
</table>

3. Upon completion of the full series, a second titer to confirm immunization is required.

<table>
<thead>
<tr>
<th>Titer Result:</th>
<th>Physician/Nurse Practitioner Name &amp; Credentials (Please Print):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive</td>
<td></td>
</tr>
<tr>
<td>Negative</td>
<td></td>
</tr>
</tbody>
</table>

(Date of Titer) (Physician/Nurse Practitioner Signature) Place Physician’s Stamp in the Above Box for Validation*

4. Please note, if the titer remains negative, the physician/nurse practitioner will need to determine follow up as appropriate and provide the School of Nursing with the plan.

***

EVIDENCE OF EACH DOSE/TITER RESULT MUST BEAR A VALIDATION STAMP AND BE SUBMITTED TO THE SCHOOL OF NURSING ONCE IT IS ADMINISTERED.

*An Official Letter from the Physician/Nurse Practitioner detailing the above may be substituted for a validation stamp.
MEASLES MUMPS RUBELLA (MMR) IMMUNIZATION

Student Name: ____________________________ CSU ID Number: _______________________

Have you received your MMR immunization?

1. If so, have a titer drawn and complete the following:

<table>
<thead>
<tr>
<th>Measles (Rubeola)</th>
<th>Mumps</th>
<th>Rubella (Measles)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Titer Result:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Positive</td>
<td>☐</td>
<td>☐ Positive</td>
</tr>
<tr>
<td>☐ Negative</td>
<td>☐</td>
<td>☐ Negative</td>
</tr>
</tbody>
</table>

Physician/Nurse Practitioner Name & Credentials (Please Print):

(Date of Titer)       (Physician/Nurse Practitioner Signature) Place Physician’s Stamp in the Above Box for Validation*

If your results are positive, you are done!

2. If any of the results are negative, re-immunization is required followed by a second titer to confirm immunization:

<table>
<thead>
<tr>
<th>Measles Mumps Rubella (MMR) Booster</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician/Nurse Practitioner Name &amp; Credentials (Please Print):</td>
</tr>
</tbody>
</table>

(Date of MMR Booster)       (Physician/Nurse Practitioner Signature) Place Physician’s Stamp in this Box for Validation*

3. Upon completion of re-immunization, a second titer to confirm immunization is required:

<table>
<thead>
<tr>
<th>Measles (Rubeola)</th>
<th>Mumps</th>
<th>Rubella (Measles)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Titer Result:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Positive</td>
<td>☐</td>
<td>☐ Positive</td>
</tr>
<tr>
<td>☐ Negative</td>
<td>☐</td>
<td>☐ Negative</td>
</tr>
</tbody>
</table>

Physician/Nurse Practitioner Name & Credentials (Please Print):

(Date of Titer)       (Physician/Nurse Practitioner Signature) Place Physician’s Stamp in the Above Box for Validation*

4. Please note, if the titer remains negative, the physician/nurse practitioner will need to determine follow up as appropriate and provide the School of Nursing with the plan.

***

EVIDENCE OF EACH DOSE/TITER RESULT MUST BEAR A VALIDATION STAMP AND BE SUBMITTED TO THE SCHOOL OF NURSING ONCE IT IS ADMINISTERED.

*An Official Letter from the Physician/Nurse Practitioner detailing the above may be substituted for a validation stamp.
VARICELLA (CHICKEN POX) IMMUNIZATION

Student Name: ___________________________ CSU ID Number: ___________________________

Have you received the Varicella (Chicken Pox) immunization or had chicken pox?

1. If so, have a titer drawn and complete the following:

<table>
<thead>
<tr>
<th>Titer Result:</th>
<th>Physician/Nurse Practitioner Name &amp; Credentials (Please Print):</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Positive □ Negative</td>
<td></td>
</tr>
</tbody>
</table>

(Date of Titer) (Physician/Nurse Practitioner Signature) Place Physician’s Stamp in the Above Box for Validation*

If your result is positive, you are done!

2. If the above result is negative, re-immunization is required followed by a second titer to confirm immunization:

**Varicella (Chicken Pox) Booster**

<table>
<thead>
<tr>
<th>Physician/Nurse Practitioner Name &amp; Credentials (Please Print):</th>
</tr>
</thead>
</table>

(Date of Varicella Booster) (Physician/Nurse Practitioner Signature)

3. Upon completion of the full series, a second titer to confirm immunization is required.

<table>
<thead>
<tr>
<th>Titer Result:</th>
<th>Physician/Nurse Practitioner Name &amp; Credentials (Please Print):</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Positive □ Negative</td>
<td></td>
</tr>
</tbody>
</table>

(Date of Titer) (Physician/Nurse Practitioner Signature) Place Physician’s Stamp in the Above Box for Validation*

4. Please note, if the titer remains negative, the physician/nurse practitioner will need to determine follow up as appropriate and provide the School of Nursing with the plan.

***

EVIDENCE OF EACH DOSE/TITER RESULT MUST BEAR A VALIDATION STAMP AND BE SUBMITTED TO THE SCHOOL OF NURSING ONCE IT IS ADMINISTERED.

*An Official Letter from the Physician/Nurse Practitioner detailing the above may be substituted for a validation stamp.
QUANTIFERON OR TUBERCULIN MANTOUX SKIN TEST
(OR CHEST X-RAY WHEN NECESSARY)

Student Name: __________________________________________________________
CSU ID Number: _______________________________________________________

STEP ONE:
Date administered: ____________________
Date read:  ____________________
Results:   Positive   Negative

To be performed 1 – 3 weeks after Step One.

STEP TWO:
Date administered: ____________________
Date read:  ____________________
Results:   Positive   Negative

To be completed by a physician/nurse practitioner after the test has been read. Please return to:
School of Nursing
2121 Euclid Avenue, JH 238
Cleveland, OH 44115-2214

The Quantiferon or two-step TB Mantoux Test report is required for all students admitted to the Nursing Program. The Quantiferon or one-step TB Mantoux Test must be performed ANNUALLY throughout the program. If chest x-ray is needed, you must attach a copy of the results with this form. Documentation must include date X-ray was read and the name and credentials of the individual who read the X-Ray.

Place Physician’s Office Stamp in the Box on the Right for Validation*:
*An Official Letter from the Physician/Nurse Practitioner detailing the above may be substituted for a validation stamp.
Student Name: _______________________________________________
CSU ID Number: ____________________________________________

Vision Screening*

*Only needs to be done if the Ability to Perform Nursing Tasks (page 4) shows you need accommodation.

<table>
<thead>
<tr>
<th>Vision</th>
<th>Right 20/</th>
<th>Corrected to 20/</th>
</tr>
</thead>
<tbody>
<tr>
<td>Left</td>
<td>20/</td>
<td>Corrected to 20/</td>
</tr>
<tr>
<td>Both</td>
<td>20/</td>
<td>Corrected to 20/</td>
</tr>
</tbody>
</table>

Optometrist Statement

This individual last visited my office on ___________________________. This patient has acceptable vision either by nature or by the use of corrective vision wear.

If vision deficits have not all been taken care of, please explain what still needs to be done:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Optometrist Name (Please Print) ________________________________________________
Office Address ________________________________________________________________
City, State Zip Code

This information must be legible and include professional credentials.

Optometrist’s Signature _________________________________________________________
Date ____________________________

Place Physician’s Office Stamp in the Box on the Right for Validation*:

*An Official Letter from the Physician/Nurse Practitioner detailing the above may be substituted for a validation stamp.
Dental Exam

Although this is optional, a dental examination is strongly recommended for all students at the time of admission to the Nursing Program. This information is strictly confidential.

Name  
(Last, First, M.I.)  

CSU I.D. No.  

The above named student is a candidate for admission into the Cleveland State University School of Nursing.

Dentist’s Statement

This individual last visited my office on ___________________________. At that time all necessary dental corrections were made.

If they have not all been taken care of, please explain what still needs to be done:

____________________________________________________________________

Dentist/Nurse Practitioner Name (Please Print)  
Office Address  
City, State  
Zip Code

This information must be legible and include professional credentials.

Dentist’s Signature  

Place Physician’s Office Stamp in the Box on the Right for Validation*:

*An Official Letter from the Physician/Nurse Practitioner detailing the above may be substituted for a validation stamp.
SEASONAL INFLUENZA (FLU SHOT) VACCINATION

*STUDENTS BEGINNING SPRING SEMESTER MUST HAVE THIS COMPLETED BEFORE START OF SEMESTER.

FLU SEASON TYPICALLY BEGINS MID SEPTEMBER.

VACCINATIONS ARE NOT AVAILABLE BEFORE THIS TIME.

Student Name: __________________________________________________________
CSU ID Number: _______________________________________________________

Please provide the following:

Date Administered ____________________________________
Lot # ______________________ Exp. Date ________________
Site of Injection: □ Left Deltoid □ Right Deltoid
Administered by __________________________________________
(Signature)
________________________________________
(Please Print Name)
Office Address: City, State Zip Code

This information must be legible and include professional credentials

Documentation must be submitted to the School of Nursing by October 15th Annually.
*An Official Letter from the Physician/Nurse Practitioner detailing the above may be substituted for a validation stamp.
Insurance Requirements and Forms:

Student Liability Insurance
- Cleveland State University covers students through a **blanket student liability insurance plan** when they are enrolled in the nursing program while participating in clinical experiences under the direction, supervision, and control of the Cleveland State University School of Nursing. The limits of liability are $1,000,000 each claim, $3,000,000 aggregate.
  - All students enrolled in a CSU Baccalaureate Nursing Program will be covered with this insurance when the Semester registration is paid.

Health Insurance Verification
- Each student must carry some form of health insurance for his/her own protection.
  - The student may obtain insurance from a private agency or participate in CSU’s Student Health Insurance Plan. Insurance plan brochures are available in the Health & Wellness Services Department, 2112 Euclid Avenue, Room 205 (IM Building), or on their website:
    - [http://www.csuohio.edu/offices/health/HealthInsurance.html](http://www.csuohio.edu/offices/health/HealthInsurance.html)

- Please document below information related to your Health Insurance coverage.

<table>
<thead>
<tr>
<th>Student’s Name</th>
<th>CSU I.D. Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Last, First, M.I.)</td>
<td></td>
</tr>
</tbody>
</table>

Policy Holder’s Name (if different from Student): ________________________________

Company Name: ________________________________________________________________

Dates of Coverage: _____________________________________________________________

Policy Number: _______________________________________________________________

Group Number: _______________________________________________________________

Automobile Information for Parking at Clinical Sites

<table>
<thead>
<tr>
<th>Student Name</th>
<th>CSU ID Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Vehicle Year</th>
<th>Make/Model</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Vehicle Plate #</th>
<th>State Issued</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Additional Clinical Agency Requirements:**

1. **Proof of a clean Background Check.** If you have been fingerprinted within the past 12 months, please provide an official copy of the results. *Third party background checks are not accepted.*

2. **Current CPR Certification**—Basic Life Support for Health Care Provider. *On-line courses are not accepted.*

**Fingerprinting and Background Check - BOTH a Civilian (BCI) Check & Federal (FBI) Check Results are required.**

- It is in your best interest to complete your background check screening in the School of Nursing Main Office as early as possible. *It can take as many as 30 days for the results to return to School of Nursing.*

**Fingerprinting Locations**

**On CSU Campus** – School of Nursing Main Office, Julka Hall, Room 238, (216) 687-3598

*No appointment is necessary, however, we would like to know that you are coming to campus.*

Bring your Proof of Payment, Driver’s License/State ID, and Request for Background Check Form (page 17).

The Combined cost of BCI & FBI Screenings is $60.00.

**Monday – Friday**

9:00 am – 4:00 pm

**Ways to Pay:**

- Credit/Debit Card ~ ShopNet:
  
  [https://campusnet.csuohio.edu/ShopNet/index.jsp?owner=SONBGRNDCHK&skip=true](https://campusnet.csuohio.edu/ShopNet/index.jsp?owner=SONBGRNDCHK&skip=true)

- Cash/Check Payments: Bring this page to the Office of Treasury Services in Main Classroom, 1899 East 22nd Street, room 115 and pay the $60 fee. Your payment must be applied to the following:

  **ACCOUNT #:** 0060-0010-0727-01-LAB_FEES

**Off Campus/In-State** – Identify fingerprint locations on National WebCheck

[www.OhioAttorneyGeneral.gov/WebCheck](http://www.OhioAttorneyGeneral.gov/WebCheck) or call 1-800-282-0515

**Off Campus/Out-of-State** – Identify fingerprint locations on the internet

- Google “where to get fingerprinted in {enter your city/state}”.
- Contact your state’s authorized Civilian and Federal Background Check Center

*If you are printed at an agency other than the School of Nursing, DO NOT use page 17.*

You will be responsible for providing the agency with the EXACT responses as listed below. *Results not received within 30 days are your responsibility to check the status.*

<table>
<thead>
<tr>
<th>Q: Reason for background check: (Be Specific)</th>
<th>Q: Address for results to be mailed to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>A: Student Entering Nursing School</td>
<td>A: CSU School of Nursing</td>
</tr>
<tr>
<td></td>
<td>2121 Euclid Avenue, JH 238</td>
</tr>
<tr>
<td></td>
<td>Cleveland, OH 44115</td>
</tr>
</tbody>
</table>
For Fingerprinting Use At The CSU School of Nursing Main Office ONLY:

Request for a Background Check via Electronic Fingerprinting

() Graduate  (X) Undergraduate  () Faculty  (X) BCI and FBI

Personal Information (please print)

Name________________________________ State/Province_____________________

Date of Birth___________ SSN___________ Zip/Postal Code ___________________

Address______________________________ Phone#___________________________

City_________________________________ Driver License Exp. Date: ____________

<table>
<thead>
<tr>
<th>This portion only is needed for FBI background check:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex [ ] Race [ ] Height [ ] Weight [ ] Hair [ ] Eyes [ ]</td>
</tr>
</tbody>
</table>

Reason for background check (4723.09):

- (X) New Admit Nursing Student
- ☐ Graduating Nursing Senior
- ☐ Faculty
- ☐ Other: if checked must complete a different form

Address for results to be mailed to:

- ☐ CSU School of Nursing
- ☐ Ohio Board of Nursing
- ☐ Other: if checked must complete a different form

I certify that the personal identifiers provided on this form are accurate and I voluntarily and knowingly authorize the Ohio Bureau of Criminal Identification & Investigation to conduct a criminal records check for the information relating to me. I also voluntarily and knowingly authorize BCI&I to disseminate criminal arrest, conviction and juvenile delinquency adjudication records to Cleveland State University. I voluntarily and knowingly release and discharge the Ohio Attorney General’s Office, BCI&I and their employees from all claims and liability related to this authorized criminal record review and dissemination.

Signature: ______________________________________  Date: __________________________

Method of Payment:

~ShopNet without Receipt, Reference #________________________
~Cashiers Office, Receipt Attached ___________________________

Administrators Initials: ______________________

Date Results Received: ________________
Cardiopulmonary Resuscitation

All students are required to maintain CPR certification – Basic Life Support (BLS) for the Healthcare Provider. You may complete the course through any provider authorized by the American Heart Association. No other certification is acceptable. Two sources are listed below for your convenience:

○ You must submit documentation of current CPR certification.

○ If you have already completed the correct course within the past twelve months, please provide documentation (24 months from the date of certification it must be renewed).

○ Your CPR certification for Healthcare Provider MUST BE renewed every twenty four (24) months throughout the program. A copy of your two-year re-certification card must be submitted upon completion of the course biennially.

CPR Course Locations

On CSU Campus – Sigma Theta Tau, International Nu Delta Chapter

- www.csuohio.edu/nursing/progandhealth.html
- (216) 875-9874

Off Campus (Ohio) – CPR Ohio

- Register online or by phone:
  - www.cprohio.com
  - (216) 251-0747
- East: Landerwood Plaza North, 30539 Pinetree, Suite 225, Pepper Pike, OH 44124
- West: Emerald Crossing, 4760 Grayton Road, Suite 3, Cleveland, OH 44135

Off Campus (Outside Ohio)

- Contact any local provider authorized by the American Heart Association.

Agency Confidentiality and Related Forms

Signed forms are required to be assigned for clinical experiences. The attached form must be completed, signed and submitted with the other documents and forms described in this packet. Other hospitals, such as Cleveland Clinic Hospitals, MetroHealth Medical Center, and University Hospitals have an on-line system for signing their confidentiality form.

○ St. Vincent Charity Medical Center – Waiver/Confidentiality & Non-Disclosure Agreement – fill in name (print & sign) and date sections only
○ St. Vincent Charity Medical Center – ID Badge Form – fill in name and automobile information
Clinical training in a health care setting assumes certain risks, including the possibility of exposure to an infectious disease, injury from equipment or medical materials, and illness or injury to oneself, employees, patients or visitors. I understand that ST. VINCENT CHARITY MEDICAL CENTER (“Medical Center”) and its affiliates do not provide any accident, malpractice, health, medical, or workers’ compensation insurance coverage for any illness or injury I may acquire or cause at the Medical Center. I understand and agree that I waive, for myself or any heirs and/or assigns, any and all claims which I might have against the Medical Center, or its agents or representatives, in any way resulting from personal injuries, illness, or property damage sustained by me and arising out of participation in the Program at the Medical Center, except for claims arising out of the gross negligence or reckless or willful misconduct of the Medical Center or their employees.

In the event I am exposed to blood or other bodily fluids from a patient who is a carrier of a contagious or infectious disease or a patient who is, in the judgment of Medical Center, at risk of carrying a contagious or infectious disease, Medical Center shall, with my consent, administer immediate precautionary treatment consistent with current medical practice. I shall pay for the initial screening tests or prophylactic medical treatments. Medical Center shall have no responsibility for any further diagnosis, medication or treatment.

I acknowledge and assume the risk of working with patients at risk of carrying a contagious or infectious disease, except for the risk of gross negligence or willful or reckless misconduct on the part of Medical Center, its trustees, officers, agents, and employees.

CONFIDENTIALITY AND NON-DISCLOSURE AGREEMENT

It is understood that in the performance of my duties, I may obtain confidential information about or from Medical Center (“Confidential Information”). Confidential Information includes, but is not limited to, financial or proprietary data about Medical Center, information about Medical Center’s business and employees, Protected Health Information (“PHI”) (as defined below), methods of operating, development plans, programs, documentation, techniques, trade secrets, systems, know-how, policy statements and other confidential data. I will not disclose Confidential Information (including, but not limited to, PHI) to anyone, including my family and friends, under any circumstances. I agree to maintain in strict confidence all Confidential Information and will not, unless otherwise required by law, disclose such Confidential Information to any third party without Medical Center’s prior written consent. Prior to discussion of or writing about any Medical Center patient in an academic context relative to my program of study, all individually identifiable information will be removed.

I agree to maintain patient confidentiality in both written and verbal communication with other students, instructors, any other individuals, in clinical rounds or class discussion, as well as in any published materials. I understand that patient confidentiality is of such great importance that PHI is NEVER to be shared with anyone even if it is years after I participate in the Program.

“Protected Health Information” or PHI, is defined as individually identifiable health information, which is health information created, received or used by Medical Center relating to (a) the past, present or future physical or mental health or condition of a patient, or (b) payment for the provision of healthcare to a patient. PHI contains identifiers that identify a patient or for which there is a reasonable basis to believe the information can be used to identify a patient. Examples of individual identifiers include, but are not limited to, patient name, complete addresses, social security number, date of birth, medical record number and dates of treatment. PHI may include any or all of these individual identifiers coupled with a patient’s health information, examples of which are a social security number and diagnosis, date of birth and past medical history, or dates of treatment and symptoms present at the time of treatment.

I understand and agree that this signed Exhibit B shall remain effective for the duration of my student clinical rotations (or faculty duties) at the Medical Center described above.

Signed: ___________________________  Date: ___________________________

[Printed Name of Student or Faculty Member]

HIPAA training completed ___________________________ and verified by ___________________________

[Date]  [Signature of Medical Center Employee]

CLINICAL SITE TO RETAIN THIS SIGNED EXHIBIT FOR AT LEAST SIX YEARS
STUDENT

I.D. BADGE DATA SHEET

FIRST NAME ____________________________________________

LAST NAME ____________________________________________

SCHOOL _____ Cleveland State University ____________________________

Job Title: STUDENT              Dept: ____________________     Expiration Date: __________

Clinical Rotation Period      FROM: _______ / _______ / _______
TO: _______ / _______ / _______

Clinical Instructor: ___________________________     E-mail: _____________________________

VEHICLE REGISTRATION

Year: ___________ Make: _______________ Model: _______________
License Plate #: ___________________ Vehicle Color: _______________

The following to be completed by Protective Services

BADGE # ____________________     BADGE DESIGN: STUDENT

VEHICLE REG.# ___________     DATABASE GROUP: STUDENT

ACCESS

Building 24 HR  General Parking  Radiology 24 HR PED Access  4A  4B
ANC Access  Any other access required to perform within Department assigned

Uniform Information

ST. VINCENT CHARITY  MEDICAL CENTER

CLEVELAND STATE UNIVERSITY ♦ SCHOOL OF NURSING

2351 EAST 22ND STREET   CLEVELAND, OHIO 44115   P. 216 861 6200  stvincentscharity.com

A Ministry of the Sisters of Charity Health System
Basic and Accelerated Students will need to have a lab coat and full uniform. The lab coat and uniforms must be ordered from Affordable Uniforms. Please contact store to check for current hours. **Both must be ordered at least 6 weeks prior to clinical orientation.** They are located at:

<table>
<thead>
<tr>
<th>Location</th>
<th>Address</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>4916 Turney Road</td>
<td>Garfield Hts., OH 44125</td>
<td>(216) 271-9597</td>
</tr>
<tr>
<td>7647 Mentor Avenue</td>
<td>Mentor, OH 44060</td>
<td>(440) 918-9800</td>
</tr>
<tr>
<td>24777 Lorain Road</td>
<td>North Olmsted, OH 44070</td>
<td>(440) 801-1576</td>
</tr>
</tbody>
</table>

You will need to purchase the following items. Those with a “*” **must be** purchased through Affordable Uniforms. Other items can be purchased from the company or through your own sources.

<table>
<thead>
<tr>
<th>WOMEN</th>
<th>MEN</th>
</tr>
</thead>
<tbody>
<tr>
<td>*Uniform (either skirt or pant suit style).</td>
<td>*Uniform shirt and white trousers</td>
</tr>
<tr>
<td>* Lab coat</td>
<td>* Lab coat</td>
</tr>
<tr>
<td></td>
<td><strong>BOTH</strong></td>
</tr>
<tr>
<td>*CSU Name Pin</td>
<td></td>
</tr>
<tr>
<td>*CSU Student Nurse Patch (one for each uniform and lab coat)</td>
<td></td>
</tr>
<tr>
<td>Stethoscope</td>
<td></td>
</tr>
<tr>
<td>White Nurse’s Shoes (No canvas tennis shoes, open heel, or clogs may be worn. “All white” leather tennis shoes without color markings are allowed. Shoes must have closed toe and heel to meet OSHA requirements.)</td>
<td></td>
</tr>
</tbody>
</table>

**Please Note:**
- Your uniform and lab coat do not come with the CSU patch sewn on. You will need to purchase separate patches and sew them on the upper left sleeve of each uniform and lab coat. Affordable Uniforms will sew on the patches for an extra charge.
- Be sure to allow plenty of room in your tops to be able to move your arms freely, even if wearing a sweater.
- Uniforms are paid for at the time you place your order.

Also note, NUR 313 Psych Mental Health and NUR 414 Community Health Nursing have separate uniform attire that is to be worn while participating in Service Learning Activities in the Community. The approved Polo Shirt is available at CSU Bookstore (refer to page 24 for details).
For use by ABSN and BSN Students Only:

<table>
<thead>
<tr>
<th>Style</th>
<th>Sizes</th>
<th>Size</th>
<th>Qty.</th>
<th>Price</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women's Top</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cherokee Workwear Premium 4727 Two Pocket Top</td>
<td>XS-XL</td>
<td>$18.99</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Women's Pant</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cherokee Workwear Premium 4044 Drawstring Waist Pant Regular Inseam 31&quot; Petite Inseam 28&quot; Tall Inseam 33.5&quot;</td>
<td>XXS-XL</td>
<td>$21.99</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternity Top</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cherokee 2892 Two Pocket Top</td>
<td>XS-XL</td>
<td>$25.99</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternity Pant</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cherokee 2092 Elastic Band Flare Pant Regular Inseam 31&quot; Petite Inseam 28&quot;</td>
<td>XS-XL</td>
<td>$25.99</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unisex Top</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cherokee Workwear Premium 4725 Three Pocket Top</td>
<td>XS-XL</td>
<td>$19.99</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Men's Pant</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cherokee Workwear Premium 4243 Elastic Waist Pant Regular Inseam 31&quot;</td>
<td>XS-XL</td>
<td>$23.99</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Women's Jacket</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cherokee 4350 Snap Front Jacket</td>
<td>XS-XL</td>
<td>$18.99</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Prices effective January, 2016 and are subject to change.

Please call store for hours of operation and current prices.
Psych Mental Health and Community Health Nursing
Uniform Attire

- Approved Polo Shirt is available in the Viking Outfitters (CSU Bookstore).
- Khaki Pants or Khaki Shirt are to be worn.
  - **NO** shorts, capris, or leggings
- Closed toe shoes and socks/stockings are to be worn.
- This attire is to be worn during service learning & volunteering for events.

Polo Shirt Information:

- **~ Antigua Elite Tipped Collar**
- **~Color:** Pine
- **~CSU logo embroidered in white on left chest**
- **~Note:** The polos are kept behind the sales desk for nursing students at a reduced cost of $28.00 (Ask for the Manager-on-duty if there are issues).

When to purchase:

Accelerated BSN Program – prior to the 2nd Semester.
Basic BSN Program – prior to the 3rd Semester.
Student Checklist to Ensure Health Data is Up To Date

☐ Hep B Documentation of a positive titer
☐ Flu Vaccine Documentation of completion each year
☐ Varicella Documentation of a positive titer
☐ MMR Documentation of a positive titer
☐ TB Documentation of the 2-step on admission and a 1-step every year thereafter
☐ T-Dap/DT Documentation of Immunization complete
☐ Health Exam Documentation complete
☐ Eye Exam Documentation complete (see page 12)
☐ Dental Exam Documentation complete (see page 13)

Checklist to Ensure Other Requirements Have Been Met

☐ CPR (BLS) is up to date and remains current ~ Copy Attached
☐ Background Check
☐ Health Insurance Verification Complete
☐ CSU Uniform Order Completed
☐ Affiliate Hospital Confidentiality/I.D. Badge Forms Completed (highlighted section only)
☐ Ability to Perform Nursing Tasks Form completed
☐ Student Handbook ~ Memorandum of Understanding
☐ Student Handbook ~ Informed Consent

Keep this page and a copy of your documents for your records.