CRITICAL REQUIREMENTS

Please Read and Retain This Letter As Well As All Documentation for Your Records

All students admitted to the College of Nursing are required to provide documentation verifying completion of specific requirements by the date identified below. The requirements set forth are mandated for all health care providers and health profession students. Students enrolled in the RN to BSN Educational Mobility, Nursing Research (PhD), Doctor of Nursing Practice (DNP) programs will complete a background check only at this time. All other students must complete background check, drug screening and health clearance verifications.

MSN Students

<table>
<thead>
<tr>
<th>Term of 1st Enrollment</th>
<th>Orders Accepted Beginning</th>
<th>Last Date to Place Order</th>
<th>Requirements must be satisfied by</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fall Semester</td>
<td>August 1</td>
<td>November 1</td>
<td>December 22</td>
</tr>
<tr>
<td>Spring Semester</td>
<td>December 1</td>
<td>March 1</td>
<td>March 31</td>
</tr>
<tr>
<td>Summer Semester</td>
<td>April 1</td>
<td>July 1</td>
<td>July 31</td>
</tr>
</tbody>
</table>

Students will utilize CastleBranch Student Immunization Tracker to submit and track health requirements. The Immunization Tracker (Medical Document Manager) walks you through the process of fulfilling immunization and health care documentation requirements. Please see the student guide on blackboard for specific submission instructions.

Clinical clearance will be granted to you when you have completed all requirements. The Compliance Summary is for you to show to preceptors/faculty members responsible for your clinical practicums to verify that you have met the requirements. If you are unable to produce a valid compliance summary, the preceptor/faculty member will exclude you from all patient contact. Your inability to participate in required clinical experiences may be cause for withdrawing you from the course or may jeopardize your successful completion of the course and prevent your progression in the curriculum. (Please review critical requirements and clinical attendance policies on the College of Nursing Student Body Organization Blackboard.) You must be logged in to view content.

REQUIREMENTS

1) Consent and Statement of Release Health clearance information and all associated documents, including lab reports and immunization history, background check & drug screening reports and personal identifiers, such as SSN, date of birth, citizenship status, address and phone number, are shared with agencies and or faculty members for the purpose of securing clinical rotations and the issuance of agency ID badges required in connection with your participation in a clinical course. This information is being released so that the clinical facility may verify your qualifications to participate in the education program offered at that facility or for auditing and accreditation purposes. All parties strictly adhere to FERPA statutes. Review and sign the consent and statement of release.

2) Emergency Contact Form If you experience a medical emergency while in the academic setting, we will notify the individual identified as your person to contact in case of an emergency. Your clinical instructor may request this information as well. We ask that you keep us informed when this information changes.

3) Driver’s License or State Identification Card a front and back copy of the card is required for issuance of the University of Cincinnati student ID badge.

4) United States Visa, if applicable If you are a non-US Citizen, you should supply a front and back copy of your US Visa as some agencies require this prior to issuing an ID badge for the rotation.

5) Health Insurance Verification is required annually by January 1. A front and back copy of the health insurance card or a statement of coverage is required. If your name does not appear on the documentation, verification from the insurance carrier is required.

6) RN Licensure Verification: Printout verification from NCSBN NURSYS Licensure QuickConfirm™ website. *If your state does not participate in QuickConfirm™, you may supply verification from your state board of nursing. Your full name, state of licensure, license number and inclusive dates of licensure must be evident. When you are in clinical settings your RN licensure must be active. In addition, you must also disclose any Advanced Nurse Practitioner Licensing credentials information.

   a) Students enrolling in clinical courses of the BSN completion program for RNs or an On-Campus graduate program specialty must be licensed to practice nursing by the state of Ohio.

   b) Students participating in the Distance Learning program must be licensed to practice nursing in your state of residence and in the state where you will complete your practicum courses.

*AL, OK do not participate in the NCSBN QuickConfirm™ Subject to change

7) CPR Verification: A front and back copy of your American Heart Association (AHA), American Red Cross (ARC), Military Training Network, or American Safety & Health Institute (ASHI) card verifying certification of completion of an adult, infant and child Basic Life Support (BLS) course in cardiopulmonary resuscitation is required. Certificates of completion from the identified agencies are acceptable if physical cards are not issued. The dates of certification must be evident. Advanced Cardiac Life Support (ACLS) may be substituted for basic life support. When you are in clinical settings your CPR certification must be current.

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8) **Continuous Professional Development Web-based Training Modules**: Submit a copy of the certificate or transcript of completion. If you experience difficulties completing the modules, please click on the Contact Us or Technical Support link on the website. The College is unable to provide technical support for the CPD website. To complete the training modules, go to the University of Cincinnati Medical Center for Continuous Professional Development website https://webcentral.uc.edu/cpd_online2/compliance/selectcategory.cfm. Select Compliance Training or Competency Testing, select Member Login, Log into the system with your Central Login (6+2) credentials, select Compliance Home, select the appropriate course, and complete the course.

   a) **Completion of Health Insurance Portability and Accountability Act (HIPAA) Privacy Compliance Training Module (Course Title: HIPAA Privacy Introduction)**: An understanding of the federal regulations mandating protection of patients’ health care information is mandated by law. Therefore, all students must complete the online module of introductory training annually.

   b) **Completion of Blood Borne Pathogens (BBP) Education Requirement**: Familiarity with measures that prevent exposure to blood-borne pathogens and appropriate actions is mandated by the federal government. You are, therefore, required to complete the Blood Borne Pathogens Web Course training annually through the University of Cincinnati.

   If you experience problems completing the modules, please click on the Contact Us or Technical Support link on the website. The College is unable to provide technical support for the CPD website.

9) **Tuberculosis (TB) Screening Annual** TB screening is required when in clinical settings as a CoN student. Please remember that your role as a student differs from your role as an employee, consequently, your employee exemption status from the TB requirement is not recognized by the University. All students participating in clinical on behalf of the College of Nursing must satisfy the TB screening component. Neither pregnancy nor Bacille Calmette-Guerin (BCG) vaccine are considered exclusions for the tuberculin screening requirement. The PPD cannot be administered within 30 days of the most recent MMR.

   The TB component may be satisfied by submitting sufficient documentation of one of the following:

   i) A QuantiFERON® Gold Blood Test within the past 12 months; or

   ii) A Two-Step Mantoux Test within the last 12 months; or

   iii) Two (2) successive annual one-step Mantoux tests with the last test completed within the past 12 months; or

   iv) Individuals with a history of reactive (positive) TB tests must provide documentation that they have been evaluated and determined not to have communicable TB. A copy of the chest x-ray report dated within the last 12 months must be included. An abnormal chest x-ray requires documentation of medication regimen. Positive responders must complete and submit a yearly TB questionnaire to document symptoms of active TB.

10) **Completed Immunization Requirements** should be documented on the Health Requirements Report Form: If you require any vaccinations, titer tests, TB testing or follow-up X-rays, they may be obtained from a private health care provider (HCP), University Health Services (513-584-4457) or through your local County Health Department. Certified Background can direct you to approved pharmacies or LabCorp laboratories where a vaccine or blood draw is performed. Negative or equivocal titers require revaccination followed by a second serologic testing. The PPD cannot be administered within 30 days after the most recent MMR. Medical contraindications should be documented on Part IV Medical Waiver for Vaccination.

   Enclose a copy of a marriage license or official name change documentation if the name on your records does not match a name which you have registered with the University. Your immunization record must include month, day and year on all vaccinations. Provide a copy of the laboratory report on all immune titers/serologic testing and chest x-rays.

   a) **Immunity to Varicella Zoster Virus** - VZV (Chicken Pox), Measles (Rubella), Mumps and Rubella (German Measles) MMR, and Hepatitis B Virus must be documented by titers. Vaccinations are not required if you have positive serology. If titers do not demonstrate positive serology, revaccination followed by a second serologic testing is required. Submit documentation of all immunizations and titer testing.

   The Hepatitis-B vaccination series takes approximately 6-8 months for completion. Therefore, you must get started with the series immediately, if you are not already immunized. All individuals with potential exposure to human tissues (e.g., biopsy or pathology specimens), human blood or human body fluids have must have documented immunity to or be immunized against Hepatitis B virus.

   Provided you receive the first two injections and demonstrate compliance in receiving subsequent injections and titer testing, you will not be excluded from courses. Complete and sign the Waiver for Incomplete Hepatitis-B Vaccine Series section of the Health Requirements Report Form Part III. Administered vaccines should be documented on the Health Requirements Report Form or through supporting documentation.

<table>
<thead>
<tr>
<th>Disease</th>
<th>Doses</th>
<th>Dosage Schedule</th>
</tr>
</thead>
<tbody>
<tr>
<td>VZV</td>
<td>2</td>
<td>6-8 weeks apart</td>
</tr>
<tr>
<td>MMR</td>
<td>2</td>
<td>after 12 months of age, at least 1 month apart</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>3</td>
<td>the first 2 doses given a month apart, and the 3rd dose given at least 4 months after the 2nd</td>
</tr>
</tbody>
</table>
11) **Evidence of Polio immunization** Documentation of completion of a series of 3 polio injections over the period of 6 months. **Declination accepted.** Please complete Part II, section 3 of the health requirements report form.

12) **Evidence of Adult Combined Tetanus, Diphtheria and Pertussis (Tdap) immunization after 2005** is required if your last Tetanus Diphtheria (TD) vaccination was more than 2 years ago. If less than 2 years have lapsed since your last TD vaccination, complete and sign the **Waiver for Incomplete Tdap Vaccine** section of the Health Requirements Report Form Part III. Provide supporting documentation for receipt of the TD vaccine.

If medical contraindications prevent you from receiving the Tdap vaccination, you should provide documentation of receipt of a TD vaccination within the past 10 years and then document your contraindication on Part IV Medical Waiver for Vaccination.

13) **Evidence of Annual Seasonal Influenza Vaccination** is required for students participating in clinical experiences in the months of October through March. The College does not have authority to exempt you from the requirement. However, your clinical agency may provide written authorization to exempt you from the requirement, please complete the College Annual Seasonal Influenza Vaccine form. The due date is November 1st unless required earlier by your clinical agency.

14) **Background Checks and Drug Screening** will be conducted through CastleBranch and is required upon matriculation into a degree program. Subsequent retesting will be determined by site specific requirements. Package codes for placing orders are identified on blackboard.

   a) **Traditional and Accelerated BSN degree students:** Your clinical rotations will cycle through agencies that require background checks and drug screening throughout your tenure in the BSN program. Hence, a national & state fingerprint-based background check, healthcare sanctions check, and urine drug screening will be performed upon matriculation into the program. Subsequent retesting for the state level background check, healthcare sanctions and urine drug screening will be required each year thereafter no later than 8 weeks prior to the start of the academic year. See Ohio HB160/SB38 for a list of offenses which may disqualify you from placement with one or more of our practice partners.

   b) **Campus Based Graduate Program and Ohio Residents in the Distance Learning Graduate Program** will complete a national & state fingerprint-based background check, healthcare sanctions check, and urine drug screening upon matriculation into the program. Subsequent retesting will be determined by site specific requirements.

   c) **Out of State Residents in Distance Learning Programs** will complete a national or state specific background check (dependent upon state of clinical rotations), healthcare sanctions check and urine drug screening upon matriculation into the program. Subsequent retesting will be determined by site specific requirements.

   d) **RN to BSN, DNP, and PhD Program students** will complete a national or state specific background check (dependent upon state of residency), healthcare sanctions check and urine drug screening upon matriculation into the program. Subsequent retesting will be determined by site specific requirements.

15) **Site-Specific Requirements** are posted in Clinical Orientation Documents folder on blackboard by agency. You are responsible for adhering to agency requirements in addition to the CoN standard critical requirements. It is recommended that you check the orientation documents folder 7 weeks before the start of a term which you plan to participate in a clinical experience.

   Documentation submitted after the identified deadline may delay your clinical rotation. Therefore it is imperative that you submit documentation on time and in the manner specified.
HEALTH REQUIREMENTS REPORT FORM

PART I  STUDENT INFORMATION—TO BE COMPLETED, REVIEWED, AND SIGNED BY STUDENT

Please Print
Full Name ________________________________ Student ID: ____________________________

Last Name     First Name     Middle Initial     UCID: Mxx-xx-xxxx    DOB: MM/ DD / YYYY

BSN Programs: [ ] Accelerated  [ ] Traditional  [ ] RN/BSN Campus  [ ] Graduate Programs: [ ] PhD  [ ] DNP  [ ] MSN: Specialty: ____________________________

Distance Lrng: [ ]

I understand the agency to which I am assigned may require more health data than listed below. I authorize the College to release my health clearance information and all associated documents, including lab reports, immunization history and background check & drug screening reports, to any agency or faculty member who may require it in connection with my participation in clinical.

Student Signature ____________________________ Date __________

Clinical Begin Term:  [ ] Fall  [ ] Spring  [ ] Summer 201___

PART II  IMMUNIZATION HISTORY— TO BE COMPLETED, REVIEWED, AND SIGNED BY HEALTH CARE PROVIDER (Supporting documentation may be attached in lieu of completing Part II)

Incomplete vaccination series must be documented on Part III. Medical contraindications must be documented on Part IV Medical Waiver for Vaccination.

1. Absence of Tuberculosis (TB) screening within the past 12 months required (ONE Quantiferon® Gold Blood Test or ONE 2-Step Mantoux/PPD test or TWO consecutive annual Mantoux/PPD tests or Chest x-ray)

<table>
<thead>
<tr>
<th>Type</th>
<th>Date Admin</th>
<th>Date Read</th>
<th>Result</th>
<th>Read By</th>
<th>Chest X-RAY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step/Annual 1</td>
<td>/</td>
<td>/</td>
<td>Neg</td>
<td>/</td>
<td>/</td>
</tr>
<tr>
<td>QFT-Gold</td>
<td>/</td>
<td>/</td>
<td>Pos</td>
<td>/</td>
<td>/</td>
</tr>
<tr>
<td>Step/Annual 2</td>
<td>/</td>
<td>/</td>
<td>Neg</td>
<td>/</td>
<td>/</td>
</tr>
<tr>
<td>QFT-Gold</td>
<td>/</td>
<td>/</td>
<td>Pos</td>
<td>/</td>
<td>/</td>
</tr>
</tbody>
</table>

Person is free of communicable tuberculosis [ ] Yes [ ] No

2. Immunity To Measles (Rubeola), Mumps & Rubella (German Measles) (MMR), Varicella (Chicken Pox) and Hepatitis B TITERS REQUIRED **Vaccinations are not necessary if positive titers are provided** If Titer is negative or equivocal, supply documentation of first series and any booster vaccinations. Retesting is required for Varicella and Hepatitis B. Upon full booster series and second negative titer, you will be considered a non seroconverter.

<table>
<thead>
<tr>
<th>Disease</th>
<th>Initial Test Date</th>
<th>Retest Date</th>
<th>Initial Series</th>
<th>Booster Series</th>
</tr>
</thead>
<tbody>
<tr>
<td>Varicella</td>
<td>/</td>
<td>/</td>
<td>1. /</td>
<td>2. /</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1. /</td>
<td>2. /</td>
</tr>
<tr>
<td>Measles</td>
<td>/</td>
<td>/</td>
<td>1. /</td>
<td>2. /</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1. /</td>
<td>2. /</td>
</tr>
<tr>
<td>Mumps</td>
<td>/</td>
<td>/</td>
<td>1. /</td>
<td>2. /</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1. /</td>
<td>2. /</td>
</tr>
<tr>
<td>Rubella</td>
<td>/</td>
<td>/</td>
<td>1. /</td>
<td>2. /</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>1. /</td>
<td>2. /</td>
</tr>
<tr>
<td>Hepatitis-B</td>
<td>/</td>
<td>/</td>
<td>1. /</td>
<td>2. /</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1. /</td>
<td>2. /</td>
</tr>
</tbody>
</table>

1. Polio Vaccination
Dose 1: / / /  Dose 2: / / /  Dose 3: / / /
[ ] Declined, never vaccinated  [ ] Declined, cannot locate records

2. Adult Combined Tetanus, Diphtheria, Pertussis Immunization After 2005
Dosage Date: / /  [ ] TD within 2 years, complete Section 3 Waiver

3. Annual Seasonal Flu Vaccination (Required for practicums occurring Oct-Mar)
Dosage Date: / /  [ ] Seeking exemption, complete application for exemption

Provider Address or Stamp ____________________________ Telephone ____________________________

Provider’s Printed Name ____________________________ Provider’s Signature ____________________________ Date __________

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### PART III- WAIVER FOR INCOMPLETE VACCINATION SERIES— TO BE COMPLETED, REVIEWED, AND SIGNED BY STUDENT

The Hepatitis B and the Adult Combined Tetanus, Diphtheria, Pertussis vaccinations follow a strict dosage schedule. You must remain on schedule to continue enrollment and participation in your practicum course(s). Administered vaccinations must be documented by your Health Care Provider on your Health Requirements Report Form or on supporting documentation i.e. immunization records. Document your progress in the appropriate fields and sign where indicated.

#### WAIVER FOR INCOMPLETE HEPATITIS B VACCINE SERIES

I understand that this waiver is valid only until the date that my series AND titer testing is scheduled for completion. I agree to provide verification immediately upon completion of the series AND titer testing or I will be ineligible to continue in my practicum course(s). I further understand that until I complete the vaccination series, I continue to be at risk for acquiring the Hepatitis B Virus Infection.

Please enter dates (mm/dd/yyyy) as appropriate and sign below.

Has received the following doses of the Hepatitis B Vaccine Series:

<table>
<thead>
<tr>
<th>Dose 1</th>
<th>Dose 2</th>
<th>Dose 3</th>
</tr>
</thead>
</table>

Is scheduled for dose 3 and/or titer testing as indicated below:

<table>
<thead>
<tr>
<th>Dose 3</th>
<th>Titer Date</th>
</tr>
</thead>
</table>

__________________________
**Student Signature**

__________________________
**Date**

#### WAIVER FOR INCOMPLETE Tdap VACCINE

I understand that this waiver is valid for two years following receipt of my last Tetanus Diphtheria vaccination. I agree to provide verification immediately upon receipt of the Adult Tdap vaccine or I will be ineligible to continue in my practicum course(s). I further understand that until I complete the vaccination, I continue to be at risk for acquiring the Pertussis virus Infection.

Please enter date (mm/dd/yyyy) of last Tetanus Diphtheria vaccine and sign below.

Dosage Date: ________________________________

__________________________
**Signature**

__________________________
**Date**
PART IV MEDICAL WAIVER FOR VACCINATION

Section 1: To Be Completed by Student
Directions: Complete Section 1 then submit the form to your Health Care Provider for completion of Section 2. Student should return completed form and necessary medical documentation to the College. Medical conditions, allergies and pregnancy require medical documentation. Breastfeeding exemptions must be obtained each semester. Allergy and certain medical conditions may involve a permanent exemption. Submit Questions to 513-558-5075 or conoad@UC.edu.

I am requesting a medical exemption for the following required vaccine(s): Varicella/Chicken Pox Measles Mumps Rubella Hepatitis B Polio Tdap

I am requesting a medical exemption for the following required vaccine(s): Varicella/Chicken Pox Measles Mumps Rubella Hepatitis B Polio Tdap

Signature ___________________________ Date __________________

Section 2: To Be Completed by Health Care Provider (Nurse Practitioner or Physician)

Vaccine(s) Allergic to Vaccine Medical Reasons, if not allergy:
Varicella/Chicken Pox Y N Pregnancy: Due Date*
Measles Y N Breastfeeding
Mumps Y N Chronic medical condition (details required, see below)
Rubella Y N Other (details required, see below)
Hepatitis B Y N
Polio Y N
Tdap Y N

Exemption Period:
☐ Permanent exemption (for allergy and certain medical conditions)
☐ Temporary exemption; note time frame: ________________________________
*Automatically terminates after one month, if a date is not identified by HCP

Details
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

Signature ___________________________ Date __________________
Printed Name ___________________________

Office Stamp/ Address and Phone Number ___________________________
ANNUAL SEASONAL INFLUENZA VACCINE

Seasonal Influenza vaccination is required by November 1\textsuperscript{st} (unless required earlier by your clinical agency) for students participating in clinical experiences occurring October 1\textsuperscript{st}-March 31\textsuperscript{st}. Students may seek exemption by completing the application below to secure approval from the clinical agency.

<table>
<thead>
<tr>
<th>Date Administered</th>
<th>Manufacturer &amp; Lot No</th>
<th>Administered By</th>
<th>Signature</th>
</tr>
</thead>
</table>

**SEASONAL INFLUENZA VACCINATION APPLICATION FOR EXEMPTION**

Directions: Complete PART I and submit the application to your clinical agency for consideration and completion of Part II. Part III must be completed by a licensed health care provider if declining for medical reasons. You must submit an application to each agency where you are scheduled to participate in a clinical experience during the months of October through March.

**PART I: TO BE COMPLETED, REVIEWED, AND SIGNED BY STUDENT**

I understand that due to my occupational exposure, I may be at risk of acquiring an influenza infection. In addition, I may spread influenza to my patients, other healthcare workers, and my family, even if I have no symptoms. This can result in serious infection, particularly in persons at high risk for influenza complications.

I have received education about the effectiveness of influenza vaccination as well as the adverse events. I have also been given the opportunity to be vaccinated with influenza vaccine.

However, I \textit{decline} influenza vaccination at this time for the following reason:

- [ ] I have a medical reason. i.e. allergic to eggs (Complete Part III Medical Waiver on reverse side or attach statement from licensed HCP Nurse Practitioner or Physician)
- [ ] It is against my religious belief.
- [ ] I do not believe the vaccine will prevent me from getting the flu.
- [ ] Other (please explain) ______________________________________________________________

I further understand that by declining this vaccine, I continue to be at risk of acquiring influenza, potentially resulting in transmission to my patients. I also understand that it is at the Agency’s discretion to approve or deny my request for exemption from the influenza vaccination.

__Student Signature__  __Date__

**PART II: TO BE COMPLETED, REVIEWED, AND SIGNED BY AGENCY/CLINICAL PRACTICUM SITE**

Directions: Please review for consideration to determine if the student is approved for exemption of the seasonal influenza vaccine. Return the application to the student for submission to the College.

- [ ] Exempt from seasonal influenza vaccine, please provide mandatory precaution guidelines (i.e. masks)
- [ ] \textbf{NOT} exempt from seasonal influenza vaccine

Agency/Clinical Practicum Site Name

Address: _____________________________________________________________

Phone No. ___________________________________________________________

Reviewer Printed Name: _______________________________________________

Reviewer Signature ________________________________________________  Date ____________

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PART III MEDICAL WAIVER FOR INFLUENZA IMMUNIZATION

Section 1: To Be Completed by Student

Name  ___________________________________________  UC ID  M -- --

Section 2: To Be Completed by Health Care Provider (Nurse Practitioner or Physician)

Vaccine(s) exemption requested:  
☐ Seasonal Flu Vaccine  
☐ Novel Flu Vaccine  
☐ Other (Please specify)  
_____________________

Medical reason(s):  
☐ Severe egg allergies  
☐ Previous Guillain-Barre syndrome within 6 weeks of getting an influenza vaccine  
☐ Previous severe reaction to an influenza vaccination  
☐ Chronic medical condition (details required, see below)  
☐ Other (details required, see below)

Exemption Period:  
☐ Permanent exemption request  
☐ Temporary exemption request; note time frame: ________________________________

Details

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

Printed Name  ___________________________________________  Date  ____________

Signature  ________________________________________________________________

Office Stamp/ Address and Phone Number

Return completed form to the student for submission to the College of Nursing.

Submit Questions to 513-558-5075 or conoad@UC.edu.
CONSENT AND STATEMENT OF RELEASE

Enrollment and participation at the University of Cincinnati College of Nursing (UC-CoN) requires that students provide proof of general and specific health status, immunization status, CPR certification, criminal background check, social security number, citizenship status including current Visa standing, driver's license/photo identification card, telephone and address data, urine/blood tests for drug screening and any other information that may be required by the college or clinical facility policy or legal mandate to establish students’ fitness to care for live patients in a clinical setting. I am aware that if during the course of the academic year(s) requiring my participation in clinical experiences, my health status should change in a way that would impact my ability to perform in clinical; I must notify the Director of the program. The need for additional clearance will be determined at that time.

Some University-affiliated clinical facilities may also require disclosure of a student's background check report and drug screening results prior to permitting the student to participate in the educational program at the facility. A favorable review of this information by the UC-CoN for enrollment into a clinical course is not binding upon a clinical facility. A clinical facility may refuse to permit a student to participate in the clinical practicum at the facility if the health clearance information, background check information or drug screening results are not provided, or if upon review of a student's health clearance information, background check and drug screening, determines the student is disqualified.

Choosing not to provide permission for the release of this information will prohibit participation in UC CoN Programs as it will result in a ban from the clinical facilities where students are required to complete the clinical portion of training. Admission to and successful completion of the clinical training portions of courses are required for program enrollment and completion.

I hereby authorize the University of Cincinnati, College of Nursing to release personal data, health clearance information and all associated documents, including lab reports and immunization history and background check and drug screening reports in its possession to affiliated clinical facilities that I may attend as part of my educational requirements. I further authorize the University of Cincinnati College of Nursing to obtain and review background check reports and drug screenings. This information is being released so that the clinical facility may verify my qualifications to participate in the educational program offered at that facility or for auditing and accreditation purposes. I further authorize University of Cincinnati College of Nursing permission to access and release certain personal identifying information, such as identification numbers, for the purposes stated herein.

I may revoke this consent at any time by providing written notice of such revocation to University of Cincinnati College of Nursing. I understand that revocation of this consent will result in ineligibility to enroll in and/or continue in any University of Cincinnati College of Nursing practicum course. This authorization is in effect for the duration of my participation and enrollment in University of Cincinnati College of Nursing programs unless revoked in writing.

University of Cincinnati, College of Nursing shall at all times comply with the applicable provisions of the Family Educational Rights and Privacy Act of 1974, 20 USC 1232(g), (FERPA).

Printed Name

_________________________

Signature

_________________________

Date

Front Copy of Driver’s License Here
EMERGENCY CONTACT FORM

Emergencies sometimes occur when you are in the clinical field. Please identify an individual that you authorize the College to contact in these situations and provide the requested information below.

*Emergency situations may include instances where you must be removed from the academic setting (clinical or classroom) due to medical conditions and require transportation to a medical treatment facility.*

**Best practices dictate that you keep this information updated with the College and your clinical instructors.**

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Phone</td>
<td></td>
</tr>
<tr>
<td>Cell Phone</td>
<td></td>
</tr>
<tr>
<td>Work Phone</td>
<td></td>
</tr>
<tr>
<td>Street Address</td>
<td></td>
</tr>
<tr>
<td>City</td>
<td>State</td>
</tr>
</tbody>
</table>

**Student Signature**

**Date**