

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

Term of 1 st Enrollment	Orders Accepted Beginning	Last Date to Place Order	Requirements must be satisfied by
Fall Semester	August 1	November 1	December 22
Spring Semester	December 1	March 1	March 31
Summer Semester	April 1	July 1	July 31

Students will utilize **Certified Background 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.

R E Q U I R E M E N T S

- 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 release 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 Licensure 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.

- a) CPR courses must contain both a written and skills assessment to satisfy the College of Nursing CPR requirement. Courses which are taught and completed entirely online are **not** acceptable. See FAQs for a list of acceptable courses. **AHA HeartSaver is not acceptable.**
- 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://ce.uc.edu/cpd>. 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 after 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, titers, 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 (Rubeola), 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 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.

Disease	Doses	Dosage Schedule
VZV	2	6-8 weeks apart
MMR	2	after 12 months of age, at least 1 month apart
Hepatitis B	3	the first 2 doses given a month apart, and the 3 rd dose given at least 4 months after the 2 nd

- 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 Certified Background 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.
- 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.
 - 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.
 - 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.
 - 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 M DOB _____
Last First Middle UCID: Mxx-xx-xxxx 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 which may require it in connection with my participation in clinical.

Student Signature Date Fall Spring Summer 201__ -- 201__
Clinical Begin Term

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 in 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)

Type	Date Admin	Date Read	Result	Read By	Chest X-RAY Required if skin/blood test is positive (please enclose a copy of the x-ray report)
<input type="checkbox"/> Step/Annual 1 <input type="checkbox"/> QFT-Gold	/ /	/ /	<input type="checkbox"/> Neg <input type="checkbox"/> Pos		Film _____ Date: / / <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal (Enclose Regimen)
<input type="checkbox"/> Step/Annual 2 <input type="checkbox"/> QFT-Gold	/ /	/ /	<input type="checkbox"/> Neg <input type="checkbox"/> Pos		Person is free of communicable tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> 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.

Disease	(Attach Lab Report)		Initial Series				Booster Series			(Attach Lab Report)		
	Initial Test Date	Retest Date <input type="checkbox"/> Neg <input type="checkbox"/> Pos	1.	2.	3.	1.	2.	3.	Retest Date	Result <input type="checkbox"/> Neg <input type="checkbox"/> Pos	Non Sero Convert	
Varicella	/ /	<input type="checkbox"/> Neg <input type="checkbox"/> Pos	1. / /	2. / /		1. / /	2. / /		/ /	<input type="checkbox"/> Neg <input type="checkbox"/> Pos	<input type="checkbox"/>	
Measles	/ /	<input type="checkbox"/> Neg <input type="checkbox"/> Pos	1. / /	2. / /		1. / /	2. / /					
Mumps	/ /	<input type="checkbox"/> Neg <input type="checkbox"/> Pos	1. / /	2. / /		1. / /	2. / /					
Rubella	/ /	<input type="checkbox"/> Neg <input type="checkbox"/> Pos	1. / /	2. / /		1. / /	2. / /					
Hepatitis-B	/ /	<input type="checkbox"/> Neg <input type="checkbox"/> Pos	1. / /	2. / /	3. / /	1. / /	2. / /	3. / /	/ /	<input type="checkbox"/> Neg <input type="checkbox"/> Pos	<input type="checkbox"/>	

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

Please Print Full Name _____ Student ID M DOB _____
Last First Middle Mxx-xx-xxxx MM / DD / YYYY

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.

Please Print
Full Name

_____ Student ID M _____ DOB _____
 Last First Middle Mxx-xx-xxxx MM / DD / YYYY

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

Please Print
Full Name _____ Student ID M _____ DOB _____
Last First Middle Mxx-xx-xxxx MM / DD / YYYY

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.

Name		Relationship
Home Phone	Cell Phone	Work Phone
Street Address		
City	State	Zip
Student Signature		Date