ADVANCED PRACTICE 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 the completion of specific requirements by the date identified below. The requirements set forth are mandated for all health professions students. As a master's, doctoral, post-master's, or post-baccalaureate student, you must complete a background check, drug screening, and health clearance verifications. Clinical clearance will be granted to you when you have completed all requirements.

The college asks all students to refrain from purchasing a critical requirements package **until the first day of course instruction for any degree or certificate program**.

Critical Requirement Submission Timeline

MSN and DNP Programs

First Term of Enrollment	Last Day to Place Order	Deadline to Complete Requirements
Fall	December 15	March 31
Spring	April 30	July 31
Summer	July 1	November 30

*Note: Students enrolled in the **BSN to DNP Nurse Anesthesia** program follow a different timeline and will receive guidance related to critical requirements in their welcome information as they prepare to begin the program.*

Certificate Programs

First Term of Enrollment	Last Day to Place Order	Deadline to Complete Requirements
Fall	September 30	September 30
Spring	February 15	February 15
Summer	June 15	June 15

Students will utilize ***CastleBranch*** to submit and track requirements. The Compliance Tracker walks you through the process of fulfilling immunization and health care documentation requirements. Please see the student guide on the Critical Requirements landing page [https://nursing.uc.edu/admissions-financial-aid/admitted-students/graduate/critical-requirements.html] 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, practicum, and/or internship 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, practicum and/or internship experiences may cause withdrawal 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 **Critical Requirements landing page.** (https://nursing.uc.edu/admissions-financial-aid/admitted-students/graduate/critical-requirements.html]) **Note**: Pre-registration is not required. Upon placing your order, you will create your unique profile and generate your login credentials. Upon creating your profile enter your Full UC ID, including the M (without dashes), and use your University of Cincinnati email address.

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 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, practicum and/or internship instructor may request this information as well. We ask that you keep us informed when this information changes and will require an annual update.

3) ***Driver's License*** *or* ***State Identification Card*** BOTH the front and the back of the license or state-issued identification card are required to be submitted on one document in the same upload submission.

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

5) ***Health Insurance Verification*** is required annually by February 15th. 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. Black out all other names that appear on the uploaded documentation.

6) ***RN Licensure Verification:*** Each graduate student (except Accelerated Direct-Entry MSN) must hold current, active, unrestricted Registered Nurse (RN) licensure with no restriction(s) or disciplinary action(s) in the state where the clinical experiences (practica and internships) are completed. PLEASE LIST ALL RN LICENSES THAT YOU HAVE. Provide a copy of your current RN License or verification of licensure through the state website. The renewal date will be set according to the expiration date of your license. NURSYS NCSBN Licensure QuickConfirm website: https://www.nursys.com. States who do not participate may submit from their respective board of nursing: the full name, license number, discipline (if any), and dates of certification required.

   a) Students in the Nurse Anesthesia, Adult-Gerontology Acute Care, Neonatal, or Pediatric Acute Care nursing specialties are **required** to be licensed in the state of Ohio:

   b) Students participating in clinical, practicum, and/or internship activities must be licensed to practice nursing in your state of residence and in the state where you will complete any practicum or internship courses.

7) ***CPR Verification:*** A front and back copy of your American Heart Association (AHA), American Red Cross (ARC), 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. **AHA HeartSaver is not acceptable.**

8) ***Web-based Compliance Training Modules:*** Submit a copy of the certificate or transcript of completion. If you experience difficulties completing the modules, please contact (513)556-HELP [4357]. The College is unable to provide technical support for the Compliance Training website.

   a) *Completion of* ***Health Insurance Portability and Accountability Act (HIPAA) Privacy Compliance Training Module (Course Title: HIPAA Compliance Training):*** An understanding of the federal regulations mandating the protection of patient's health care information is mandated by law. Therefore, all students must complete the online module of introductory training annually through the University of Cincinnati. Submit documentation of your HIPAA Compliance Training Certification.

   To complete the HIPAA training module, go to the University of Cincinnati Compliance Training website [https://ce.uc.edu/cpd/Categories]. Select ***Login,*** *Select* ***Use UC Login,*** *next, log into the system with your Central Login (6+2) credentials, select the appropriate course and complete the course.* The renewal date will be set for the last day of the month one year from the date of certification. Complete the original and renewal certification at: https://ce.uc.edu/cpd/Categories

   b) *Completion of* ***Bloodborne Pathogens (BBP)*** *Education Requirement (Course Title* ***Bloodborne Pathogens*** *from under the* ***Topics*** *menu on the left.)* 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 Bloodborne Pathogens web course training annually through the University of Cincinnati. Submit documentation of your BBP Training Certification.

   To complete the BBP training module, go to the University of Cincinnati: Environmental Health & Safety (EH&S) Training portal***,*** *Select* ***Web-Based Compliance Training****. Next, log into the system with your Central Login (6+2) credential and select and complete the* ***Bloodborne Pathogens*** *course.* The renewal date will be set for the last day of the month one year from the date of certification. Complete the original and renewal certification at: https://ehs.uc.edu/itc/compliance.aspx

   If you experience difficulties completing the modules, please contact (513)556-HELP [4357]. The College is unable to provide technical support for the Compliance Training website.

9) ***Tuberculosis (TB) Screening*** Annual TB screening is required when in clinical settings as a College of Nursing 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, practicum, and/or internship activities on behalf of the College of Nursing must satisfy the TB screening component. Neither pregnancy nor Bacille Calmette-Guerin (BCG) vaccine is considered excluded from the tuberculin screening requirement.

Special Notes:
- The PPD cannot be administered within 30 days after the most recent MMR.
- Lab report with reference range or employee health records with pos/neg and no numerical value is required for all laboratory testing.

Students may utilize the Annual TB Screening Questionnaire to record their results. The TB component may be satisfied by submitting sufficient documentation of one of the following:

   i) An IGRA blood test [QuantiFERON® Gold Plus (QFT-Plus) or T-SPOT® (T-Spot)] within the past 12 months OR

ii) A Two-Step Mantoux tuberculin skin test (TST/PPD) within the last 12 months; (Date placed and read should be evident.) OR

iii) Two (2) successive annual one-step Mantoux (TST) tests with the last test completed within the past 12 months (Date placed and read should be evident.) 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 the medication regimen. *Positive responders must complete and submit a yearly TB questionnaire to document symptoms of active TB.*

Upon renewal, one of the following is required:

v) An IGRA blood test [QuantiFERON® Gold Plus (QFT-Plus) or T-SPOT® (T-Spot)] within the past 12 months OR

vi) A One-Step Mantoux tuberculin skin test (TST/PPD) within the last 12 months (Date placed and read should be evident.) OR

vii) If PREVIOUS positive results renewal date will be set at one year to provide a TB Questionnaire.

10) ***Titer & Immunization Requirements****:* 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. CastleBranch can direct you to approved pharmacies or LabCorp laboratories where a vaccine or blood draw is performed. **The PPD cannot be administered within 30 days after the most recent MMR.** Medical contraindications should be documented on the ***MEDICAL WAIVER FOR VACCINATION*** form*.*

Special Notes:

- Enclose a copy of a marriage license or official name change documentation if the name on your records does not match a name that you have registered with the University. Your record must include month, day, and year on all vaccinations and titer testing.
- Provide a copy of the laboratory report on all titer/serologic testing and chest x-rays.
- Lab report with reference range or employee health records with pos/neg and no numerical value is required for all laboratory testing.

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 antibody titers**. Vaccinations are not required if you have positive serology. If titers do not demonstrate positive serology, revaccination followed by second serologic testing is required as specified below. Submit documentation of all (primary and booster) immunizations and titer testing.

About Titer Testing Requirements

(1) Complete ***Surface antibody titer****, not an antigen titer*
(2) ***MMR*** (Measles, Mumps, Rubella) [MMR IgG AnitibodyTiter]
(3) ***Hepatitis B*** [Quantitative Hepatitis B Surface Antibody]
(4) ***Chicken Pox*** (Varicella) [VZV IgG Titer]

What if I'm not immune?

Disease	Booster Requirements	Second Titer Required	Dosage Schedule
MMR*	1 Dose	No	1 dose
Hepatitis B	Heplisav-B 2-dose OR Engerix-B, Recombivax HB 3-dose	Yes	**Heplisav-B**: 2 doses given 1 month apart **Engerix-B, Recombivax HB**: 3-dose series on a 0, 1, and 6-month schedule
Varicella (Chicken Pox)	2 Doses	Yes	6-8 weeks apart

*If the primary MMR vaccination series is not on file, the two-dose MMR series is required to be administered at least 1 month apart

The **Hepatitis-B** vaccination series may take 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 the Hepatitis B virus.

Provided you receive the first two Hepatitis-B injections and demonstrate compliance in receiving subsequent injections and titer testing, you will not be excluded from clinical activities. Complete and sign the ***WAIVER FOR INCOMPLETE HEPATITIS-B VACCINE SERIES*** form. The Waiver for Incomplete Hepatitis B Vaccine Series must accompany each subsequent submission.

11) ***Evidence of Polio immunization*** Documentation of completion of a series of 3 polio *injections over the period of 6 months.* ***Declination accepted****.*

12) ***Evidence of Adult Combined Tetanus, Diphtheria and Pertussis (Tdap) immunization within the past 10 years*** is required. If less than 2 years have lapsed since your last TD vaccination, complete and sign the ***WAIVER FOR INCOMPLETE TDAP VACCINE*** form. 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 the **MEDICAL WAIVER FOR VACCINATION** form**.** ***Renewal will be set for 10 years after vaccination.***

13) ***Evidence of Annual Seasonal Influenza Vaccination*** is required for students participating in clinical, practicum, and/or internship experiences in the months of October through March. The College does not have the authority to exempt you from the requirement. However, your clinical agency may provide written authorization to exempt you from the requirement, please complete the **ANNUAL SEASONAL INFLUENZA VACCINE** form**. The due date is October 15th unless required earlier by your clinical agency.**

14) ***Background Checks and Drug Screening*** **will be conducted through CastleBranch and are required upon matriculation into a degree program.** The background checks are required to (i) ascertain the ability of students to eventually become licensed, registered, and/or certified in their health career profession and (ii) the ability of the students to attend mandatory clinical, practicum, and/or internship rotations at internal and external facilities in accordance with the requirements of the applicable program of study.

a) This record check may reveal both students' unsealed and sealed convictions. Please inform us immediately of any convictions, guilty pleas, or findings of guilt that occur after your enrollment here. Felony and misdemeanor records may result in an inability to progress in the nursing program and

subsequent withdrawal from the program. Subsequent retesting will be determined by site-specific requirements. Package codes for placing orders are on the student landing page.

b) Self-disclosure of criminal history is to be completed annually. A criminal history does not automatically bar you from clinical, practicum, and/or internship experiences. The College follows acceptance criteria as outlined by our clinical partners.

c) **Ohio Residents and students completing clinical activities in the state of Ohio** 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.

d) **Out-of-State Residents** will complete a national or state-specific background check (dependent upon the state of clinical, practicum, and/or internship), healthcare sanctions check, and urine drug screening upon matriculation into the program. Subsequent retesting will be determined by site-specific requirements.

e) ***Diluted drug screens must retest at the student's expense.***

15) ***Site- Specific Requirements*** are determined at the time your clinical, practicum, and/or internship is confirmed. You are responsible for adhering to agency requirements in addition to the CoN standard critical requirements. If you have any questions about site-specific requirements, please contact the respective Clinical Site Coordinator.

Documentation submitted after the identified deadline may delay your clinical, practicum, and/or internship experience. Therefore, you must submit documentation on time and in the manner specified.

University of Cincinnati
College of Nursing

Please Print

Full Name _____ Student ID M _____ DOB _____

Last First Middle Mxx-xx-xxxx MM / DD / YYYY

ANNUAL TB SCREENING QUESTIONNAIRE

SECTION A		
1.	Do you have a history of having Tuberculosis? **If YES, complete sections A and B**	☐ Yes ☐ No
2.	Do you have a history of positive TB skin test, QuantiFERON-TB Gold or T-SPOT? **If YES, complete sections A and B**	☐ Yes ☐ No
3.	Do you now have any condition requiring prolonged steroid or immunosuppressive therapy?	☐ Yes ☐ No
4.	Do you have an immunosuppressive illness at the present time?	☐ Yes ☐ No
5.	**Have you had any of** the **following** in **the past year?**	☐ Yes ☐ No
a.	Recent, close contact with any person having active tuberculosis?	☐ Yes ☐ No
b.	Unexplained cough?	☐ Yes ☐ No
c.	Coughing up blood?	☐ Yes ☐ No
d.	Unexplained weight loss or increased fatigue?	☐ Yes ☐ No
e.	Unexplained fever or night sweats?	☐ Yes ☐ No
f.	Have you ever had BCG vaccine?	☐ Yes ☐ No

SECTION B	
Did you have a chest x-ray done?	☐ Yes ☐ No
Date of last chest x-ray :	☐ Yes ☐ No
Was the chest x-ray normal?	☐ Yes ☐ No
Were you ever treated for TB?	☐ Yes ☐ No
Year treated for TB:	☐ Yes ☐ No
What medicine/s did you take? Select all that apply: ☐ Isoniazid (INH) ☐ Rifampin (RIF) ☐ Ethambutol (EMB) ☐ Pyrazinamide (PZA) ☐ Other, please specify:	
If you did not complete at least six months of therapy, please explain why:	

Have you had a live vaccine in the last 30 days ☐ Yes ☐ No

I hereby consent to the injection of the tuberculin PPD skin test. I understand that my PPD skin test must be read and documented by a physician or physician representative 48-72 hours after injection. I grant permission for the information contained in this form to be shared with other health systems, for the purpose of employment, education, or licensure.

Student Signature _____ Today's Date _____

STOP HERE If you have documentation of a positive PPD on file with the College of Nursing, you are not required to complete section C.

SECTION C

ONE STEP (or IGRA blood test) [QuantiFERON® Gold Plus or T-SPOT®]			
DATE ADMINISTERED			
Administered by			
DATE READ			
DOSE/ROUTE: *0.1 ML/intradermal*			
MFR/LOT/EXP DATE			
Site: ☐ LEFT Forearm ☐ Right Forearm			
Result: ☐ Negative ☐ Positive	MM INDURATION		
IGRA blood test result (attach lab report) ☐ Negative ☐ Positive			
Office Stamp Required			

TWO STEP (when applicable 7-21 days later)			
DATE ADMINISTERED			
Administered by			
DATE READ			
DOSE/ROUTE: *0.1 ML/intradermal*			
MFR/LOT/EXP DATE			
Site: ☐ LEFT Forearm ☐ Right Forearm			
Result: ☐ Negative ☐ Positive	MM INDURATION		
Office Stamp Required			

University of Cincinnati
College of Nursing

Please Print

Full Name _____ Student ID M _____ DOB _____

Last First Middle Mxx-xx-xxxx MM / DD / YYYY

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 clinical, practicum, and/or internship course(s). Administered vaccinations must be documented by your Health Care Provider 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 clinical, practicum, and/or internship 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 ☐ Heplisav-B 2-dose or ☐ Engerix-B, Recombivax HB 3-dose :

_____ _____ _____

Dose 1 **Dose 2** **Dose 3**

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

_____ _____

Dose 3 **Titer Date**

_____ _____

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 clinical, practicum, and/or internship 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

University of Cincinnati
College of Nursing

Please Print

Full Name _____ Student ID M_____ DOB _____

Last First Middle Mxx-xx-xxxx MM / DD / YYYY

MEDICAL WAIVER FOR VACCINATION

Directions: Complete Section 1 then submit the form to your Health Care Provider for completion of Section 2. Student should return the 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.

SECTION 1: TO BE COMPLETED BY STUDENT

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

_____ _____

Signature **Date**

SECTION 2: TO BE COMPLETED BY LICENSED PROVIDER (PHYSICIAN [MD OR DO], PHYSICIAN ASSISTANT, OR NURSE PRACTITIONER)

Vaccine(s)	Allergic to Vaccine?
☐ Varicella/Chicken Pox	☐ Yes ☐ No
☐ Measles	☐ Yes ☐ No
☐ Mumps	☐ Yes ☐ No
☐ Rubella	☐ Yes ☐ No
☐ Hepatitis B	☐ Yes ☐ No
☐ Polio	☐ Yes ☐ No
☐ Tdap	☐ Yes ☐ No
☐ Varicella/Chicken Pox	☐ Yes ☐ No

Medical Reasons, if not allergy:

☐ Pregnancy: Due Date* _____

☐ Breastfeeding

☐ Chronic medical condition *(details required, see below)*

☐ Other (details required, see below)

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

_____

Provider Signature _____ **Date** _____

Printed Name _____

Office Stamp/ Address and Phone Number _____

UNIVERSITY OF Cincinnati
College of Nursing

Please Print

Full Name _____ Student ID M _____ DOB _____

Last First Middle Mxx-xx-xxxx MM / DD / YYYY

ANNUAL SEASONAL INFLUENZA VACCINE

Seasonal Influenza vaccination is required by October 15th (unless required earlier by your clinical agency) for students participating in clinical, practicum, and/or internship experiences occurring from October 1st-March 31st. Students may seek exemption by completing the application below to secure approval from the clinical agency.

Date Administered	Manufacturer & Lot No	Administered By	Signature

SEASONAL INFLUENZA VACCINATION APPLICATION FOR EXEMPTION

Directions: Complete Section I and submit the application to your clinical agency for consideration and completion of Section II. Section 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, practicum, and/or internship experience during the months of October through March.

SECTION 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 the influenza vaccine.

However, I **decline** influenza vaccination at this time for the following reason:

☐ I have a medical reason. i.e. allergic to eggs *(Complete Section III Medical Waiver on the reverse side or attach a statement from licensed HCP (Physician [MD OR DO], Physician Assistant, or Nurse Practitioner)*

☐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**

SECTION II: TO BE COMPLETED BY CLINICAL PRACTICE PARTNER)

Directions: Please review for consideration to determine if the student is approved for exemption from 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)

☐ **NOT** exempt from seasonal influenza vaccine

Agency/Clinical Practicum Site Name _____

Address: _____

Phone No. _____

Reviewer Printed Name: _____

Reviewer Signature _____ Date _____

University of Cincinnati
College of Nursing

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

MEDICAL WAIVER FOR INFLUENZA IMMUNIZATION

SECTION III: TO BE COMPLETED LICENSED PROVIDER (PHYSICIAN [MD OR DO], PHYSICIAN ASSISTANT, OR NURSE PRACTITIONER)

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

_____
_____
_____
_____
_____
_____
_____
_____
_____

Provider Signature _____ **Date** _____

Printed Name _____

Office Stamp/ Address and Phone Number _____

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.

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 is not provided, or if upon review of a student's health clearance information, background check and drug screening, it determines the student is disqualified.

Choosing to not 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.

Initial

_____*I hereby authorize the University of Cincinnati, College of Nursing to release specific personally identifying data as required by clinical facilities. Such information may include health clearance information, lab reports, immunization history, background check and drug screening reports. 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.*

Initial

_____*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.*

Initial

_____*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). In addition, written affiliation agreements establishing clinical facilities as school officials are in place. These agreements require facilities to comply with all applicable provisions of FERPA in order to protect the privacy of the students' personally identifying information in their possession.

_____

Printed Name

_____

Signature

_____

Date

Front Copy of Driver's License Here

University of Cincinnati College of Nursing

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, practicum, and/or internship *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, practicum, and/or internship instructors.

Name **Relationship**

Home Phone **Cell Phone** **Work Phone**

Street Address

City **State** **Zip**

Student Signature **Date**

ANNUAL REVIEW RENEWAL If no information has changed, please complete the attestation below.

I do hereby attest that this information is true, accurate, and complete to the best of my knowledge

Signature Date

I do hereby attest that this information is true, accurate, and complete to the best of my knowledge

Signature Date

I do hereby attest that this information is true, accurate, and complete to the best of my knowledge

Signature Date

I do hereby attest that this information is true, accurate, and complete to the best of my knowledge

Signature Date