XU COLLEGE OF HEALTH AND HUMAN SERVICES

Patricia A. Chin School of Nursing

REQUIREMENTS FOR CLINICAL

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|  **REQUIRED DOCUMENTATION****(provide copies of all, for cards, front and back w/signature)**  | **frequency: C:\Program Files\Microsoft Office\MEDIA\OFFICE14\Bullets\BD21301_.gif** |
| American Heart Association CPR (BLS) Cert. (Health Care Provider: 2yrs) |  | Every 2 yrs  |
| California Driver License or CA ID |  | **once & when renewed**  |
| Auto Liability Insurance or attestation  |  Students name must appear on policy | **once & when renewed**   |
|  RN License  *(absn/bsn basic exempt)* |  | **once & when renewed**   |
|  Health Insurance  | Students name must appear on card | **once & when renewed**   |
|  University Liability Insurancehttps://commerce.cashnet.com/csulapay | Click “view all items” and select “Student Liability Insurance” | yearly  |
|  HIPAA certificate *(Take quiz, print certificate and upload to COMPLIO)* | Date: <https://www.csudh.edu/son/info/hipaa-precautions/hipaa-quiz>   | yearly  |
|  Background Check  *(included with COMPLIO purchase)* | Purchase Date:  | once  |
|  Live Scan  (if required by clinical site)  |  Date:  | once  |
|  Drug Screening  (UGRD included with COMPLIO - GRADS, if required by clinical site) |  Date:  | once (might repeat if needed)  |
|  Fire Card  (UGRD only - GRADS, if required by clinical site) |  Date:  | **once & when renewed**   |
| **Forms are on COMPLIO for download and the clinical placement website:** [**https://www.calstatela.edu/hhs/nursing/clinical-placement**](https://www.calstatela.edu/hhs/nursing/clinical-placement) |
| Field Trip/Off Campus Activity/Transportation Form |  | once  |
| COVID-19 Liability Form |  | yearly |
| COVID-19 Acknowledgment Form |  | once  |
| Handbook Confidentiality Statement Form |  | once  |
| Handbook Acknowledgement Form |  | once  |
| COVID-19 Training Certificate  | <https://www.calstatela.edu/ehs/covid-19-safety-protocols>  | once  |
| Biosafety Hazardous Waste Handling and Disposal (CSU Bridge) | [https://csustudents.skillport.com/skillportfe/main.action#summary/COURSES/CDE$122810:\_ ss\_cca:ehs\_hsf\_d88\_sh\_enus](https://csustudents.skillport.com/skillportfe/main.action%23summary/COURSES/CDE%24122810%3A_%20ss_cca%3Aehs_hsf_d88_sh_enus) | once  |
| Filtering Facepiece Respirators and Masks (CSU Bridge) | [https://csustudents.skillport.com/skillportfe/main.action#summary/COURSES/CDE$129717:\_ ss\_cca:ehs\_hsf\_e80\_sh\_enus](https://csustudents.skillport.com/skillportfe/main.action%23summary/COURSES/CDE%24129717%3A_%20ss_cca%3Aehs_hsf_e80_sh_enus) | once  |
| Volunteer Use Form: use link | <https://powerforms.docusign.net/55628098-938f-4d00-ab19-9b1cb75f4848?env=na2&acct=7891c003-1b6a-4447-a52d-e722502ecfaa&accountId=7891c003-1b6a-4447-a52d-e722502ecfaa>  | once  |

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| **REQUIRED HEALTH SCREENING (Immunizations): Copies of all required** **positive titers OR proof of the vaccines(series) in progress with positive titers to follow required.** | **frequency: C:\Program Files\Microsoft Office\MEDIA\OFFICE14\Bullets\BD21301_.gif** |
| MMR vaccines & Positive Titers Measles(Rubeola) Mumps Rubella | Date: #1 \_\_\_\_\_\_ Date: #2 \_\_\_\_\_Date: #3 \_\_\_\_\_\_ | once |
| Varicella (Chicken Pox) vaccine & Positive Titer | Date: #1 \_ Date: #2 \_\_\_\_\_ | once  |
| \_\_\_Hep B Series & Positive Titer or \_\_\_Declination  | Date: #1 \_\_\_\_\_\_ Date: #2 \_\_\_\_\_Date: #3 \_\_\_\_\_\_ | once |
| Tdap  | Date: \_ \_\_  | once  |
| \_\_\_Influenza (Flu) Vaccination or \_\_\_Declination | Date: \_\_\_  | yearly  |
| Physical Exam (see pg 3) |  | yearly  |
| Please submit documentation of *a current 2 step TB skin test* ***OR*** *a past 2 step TB skin test along with a current 1 step TB or X-ray* ***OR***QuantiFERON Gold Blood test. The renewal date will be set for 1 year. Upon renewal, one of the following is required: 1 step TB Skin test **OR** QuantiFERON Gold Blood test **OR** Chest X-Ray (if positive TB).  |
| TB 2-step (once to be followed by yearly 1 step, X-ray or QuantiFERON)Date: Result:  | Date: #1 \_\_\_ \_Date: #2 \_ \_ \_(one to three weeks apart) | once  |
| TB test date **OR**Last 12 months: Result: **\_\_\_\_\_\_\_\_\_\_\_** | yearly  |
| \*Positive TB provide anegative Chest X-Ray report **OR**Chest X-Ray Date: **\_\_\_\_\_\_\_\_\_** Result: **\_\_\_\_\_\_\_\_\_** | yearly  |
| QuantiFERON Gold Blood test:Date: **\_\_\_\_\_\_\_\_\_\_\_** Result: **\_\_\_\_\_\_\_\_\_\_\_** | yearly  |
| COVID-19 VACCINATION: Date: **\_\_\_\_\_\_\_\_\_\_\_** | once |
| COVID-19 VACCINATION BOOSTER: Date: **\_\_\_\_\_\_\_\_\_\_\_** | yearly |

 **California State University Los Angeles – School of Nursing**

Physical Exam Form:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ was examined on the below date and I found her/him to be in satisfactory health and able to participate fully in the School of Nursing academic program.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

                            Signature of Clinician \*

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 Printed Name

\_\_\_\_\_\_\_\_\_\_\_\_

 Date

\*This health examination is to be done by a physician, nurse practitioner, or physician’s assistant.

MD/DO \_\_\_\_\_ NP \_\_\_\_\_ PA \_\_\_\_\_

Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinician Comments:

NOTE: using this form is optional