Dear Graduate Nursing Student:

Students who are registered for NURS 640: Advanced Physical Assessment, for fall are required to complete the first step in their clinical clearance process between August 1st and August to be eligible for clinical placement for spring and summer.

Students are required to upload and manage the required documents to an account they will subscribe to with American Databank. Students will be required to pay a fee of $30 for the subscription.

Separate instructions on how to open an account with American Databank and upload the documents are on pg. 2

It is strongly recommended that students begin to complete the requirements around June 1st, or as soon as possible, in order to upload the required documentation to their American Databank account by August 1st. Students are responsible for keeping all health compliance requirements up-to-date until the completion of all clinical hours required for their program.

Students who are resuming studies into clinical for spring or summer are required to follow the clinical clearance process as well. The deadline to submit all documents will be August 1st. Any student registered for NURS 640 who has not fulfilled this requirement may be dropped from the course.

HEALTH REQUIREMENTS FOR FIRST TIME CLINICAL (LAB) STUDENTS:

1. A completed Annual Health Assessment form: Required for the annual physical, annual PPD or IGRA Blood test [QuantiFeron or T-Spot], and TDAP shot (every 10 years) – (This form is on page 3 of this pdf packet).

   *If you are PPD positive, 2 page TB Screening Form is required annually along with a copy of your last chest X-ray report (This form is on pgs. 4-6)- NOTE: TB Screening Form is NOT required if you are PPD negative. Also note some sites require you to fulfill PPD requirement every 6 months. You will be notified if this applies to you

2. A completed Titer Documentation form and lab reports: (Mandatory blood work for MMR, Varicella/Hepatitis B) (This form is included on page 7). Please provide matching lab results along with the completed titer form as proof.

   • If blood work for Mumps, Measles or Rubella is non-immune or equivocal, a booster shot is required and must be documented on the MMR booster form, then 4-8 weeks later, post titer(s) will need to be redrawn. (This is on pg. 8). Note: MMR Booster form is not required if all titers are positive/immune.
   • If your blood work for Varicella is non-immune or equivocal, 2 Varicella boosters are required (1 month apart) and must be documented on the Varicella Booster form. (This is on pg. 9)
   • If your blood work for Hepatitis B is non-reactive, a Hepatitis B Declination form must be completed.

   PLEASE NOTE THE DECLINATION FORM DOES NOT DECLINE THE BLOOD WORK- BLOOD WORK IS MANDATORY

3. A copy of the front and back of your CPR card or certificate from a verified and approved ARC or AHA company

   • The correct class is for the adult, child and infant with AED- Typically called the BLS for Health care professionals or providers. ACLS is also acceptable. A list of suggested CPR companies is attached (pg. 11)

4. A copy of your New York Registered Nursing License

   • The green registration certificate portion showing your address and license expiration date is required as a copy.

5. *Flu Vaccination: Students are required to either have a seasonal flu vaccination or if declining the vaccination due to allergy, medical provider must fill out the exemption form and a respiratory mask must be worn during clinical. *DEADLINE DATE: (typically the deadline is first or second week of October)-You do not need this by Aug 1st.

   • You may use the seasonal influenza form (on pg.12) and upload it to your Complio account. If using your own document, please ensure your name, date administered, vaccine lot #, and provider’s signature / facility information are all on it. If you are allergic to eggs or have had adverse reactions in the past please have your medical provider fill out the Exemption Form (on pg.13) Flu shots are renewed every fall semester.

Please read the Annual Health Assessment form, * TB screening form, and Titer Documentation form. Make sure that they are completed in their entirety. A Doctor or Nurse Practitioner must document the information on these forms, and they must sign, date, and stamp the bottom of the forms with their credentials. Please note that you must update and submit to American Databank a copy of your CPR, RN License, Physical, and PPD before the expiration dates noted on your documents until you complete your program.

*Once health clear and registered, you may have additional requirements, specifically mandated by the clinical site you are assigned to and depending on your clinical level. This may include a criminal background check and drug test at your expense.

DEADLINE for all requirements listed above: AUGUST 1st

Any questions, feel free to email me: mcoletto@pace.edu- Thank you, Marilena Coletto
Welcome to Complio!

Complio is an online tracking system, selected by your school, to host details and documentation proving your compliance with immunizations and other requirements. Follow these step-by-step instructions to create an account and move towards compliance.

Create your Account

Step 1: Create an account by going to https://pace.complio.com. Navigate to the Complio homepage by following the prompts on the page. Click Create an Account to get started. Enter your personal information. Be extra careful with your Email Address, as you will need to respond to an email from Complio to complete your Account Creation.

Step 2: Complio will send an email to the address used during account creation. Click on the Activation Link within the message.

Subscribe

Step 3: An Account is not the same as a Subscription! Before you can begin entering information, you will need to order a subscription. Click Complete Pending Order to get started. Select the appropriate Department - Nursing, then Program — Graduate. Your required subscription plan will automatically populate to complete the order.

Step 4: Carefully enter the information required to complete your order. Please read the Disclaimer on the next screen and click Accept & Proceed to continue.

Step 5: Review your information on the Order Review screen. If everything is correct, enter your payment. You can pay by credit card or money order. Depending on your Payment Method, it may take a little while for your account to be activated.

Add Details & Documents

Step 6: Login in and click Enter Data with your personal dashboard.

Step 7: Click Upload Documents and follow the onscreen instructions. Detailed instructions for document upload are provided in the full User Guide.

Step 8: Click Enter Requirement to add details for a specific requirement. There may be multiple options, but you may not need to complete them all. Refer to the Note for explanation of options.

Step 9: Select a Requirement, complete the required fields and select from the drop-down list of document you’ve uploaded. Click Submit to save what you’ve entered. You can Update the item at any time before it is approved.

Wait for Approval
At this time, the requirement is pending review and approval by an Administrator. American DataBank verifies items within 1-3 business day (excluding holidays and weekend); if your school is reviewing, the timeframe may be different.

Monitor Your Status
We recommend checking Complio regularly. You are not fully compliant until your Overall Compliance Status = Compliant, indicated with a Green Checkmark. Complio will notify you via email when your compliance status changes, if an item is approaching expiration or if a new requirement is added.

Questions?
Please contact American DataBank if you have questions about your account, compliance requirements, or using Complio. We are available to assist you Monday-Friday 7am-6pm MT (Denver). You can contact us via email to complio@americandatabank.com or by calling (800) 200-0853.
ANNUAL HEALTH ASSESSMENT

THIS SECTION IS TO BE COMPLETED BY PATIENT

CURRENT SEMESTER: ☐ FALL ☐ SPRING ☐ SUMMER YEAR: ____________
PACE ID#: U_____________ DATE OF BIRTH: / / CAMPUS: ☐ NYC ☐ PLV
LAST NAME: ___________________ FIRST NAME: ___________________
PACE EMAIL: ___________________ PERSONAL EMAIL: ___________________
PHONE# (HOME): ___________ (CELL): ___________ (WORK): ___________

I HEREBY AUTHORIZE PACE UNIVERSITY TO RELEASE ANY INFORMATION BELOW TO ANY HEALTH CARE PROVIDER WHICH MAY REQUIRE SAME IN CONNECTION WITH MY PARTICIPATION IN A CLINICAL COURSE. I UNDERSTAND THE AGENCY TO WHICH I AM ASSIGNED MAY REQUIRE MORE HEALTH DATA THAN LISTED BELOW.

PATIENT SIGNATURE: ___________________ DATE: ____________

ALL 3 SECTIONS BELOW MUST BE COMPLETED BY HEALTH CARE PROVIDER

SECTION 1: COMPLETE HISTORY AND PHYSICAL EXAMINATION [REQUIRED ANNUALLY]

DATE

Full date (mm/dd/year) must be filled out for this section in addition to dating this form below.

SECTION 2: PPD (TST MANTOUX) [REQUIRED ANNUALLY, UNLESS OTHERWISE NOTIFIED]

DATE PLACED: ________________

DATE READ: ________________

RESULT: ☐ NEGATIVE ☐ POSITIVE

INDURATION (MM): ________________

PPD ALTERNATIVE: AN ANNUAL FDA-APPROVED IGRA BLOOD TEST (QUANTIFERON TB GOLD OR T-SPOT) [COPY OF LAB REPORT REQUIRED]

In the case of a positive PPD or positive IGRA blood test, patient must complete the attached Tuberculosis (TB) Screening Form Part A, and patient’s health care provider must complete Part B. Patient’s health care provider must follow the guidance from the NYS Department of Health, and provide the appropriate documentation in Part B to complete this portion of their health clearance.

SECTION 3: TDAP VACCINE (TETANUS TOXOID, REDUCED DIPHTHERIA TOXOID AND ACELLULAR PERTUSSIS) [REQUIRED EVERY 10 YEARS]

DATE

Full date (mm/dd/year) must be filled out for this section in addition to dating this form below.

I FIND HIM/HER TO BE IN GOOD HEALTH. HE/SHE IS FREE FROM A HEALTH IMPAIRMENT WHICH MAY POSE POTENTIAL RISK TO PATIENTS OR PERSONNEL, OR WHICH MAY INTERFERE WITH THE PERFORMANCE OF NURSING RESPONSIBILITIES. HABITUATIONS TO ALCOHOL OR OTHER DRUGS WHICH MAY ALTER THE INDIVIDUAL’S BEHAVIOR HAS BEEN CONSIDERED IN THIS EVALUATION. MY SIGNATURE INDICATES THE INDIVIDUAL IS ABLE TO FULLY PARTICIPATE IN NURSING PRACTICE.

SIGNATURE OF EXAMINING CERTIFIED NURSE PRACTITIONER OR PHYSICIAN: ___________________

(STAMP IS NOT ACCEPTABLE IN PLACE OF SIGNATURE)

DATE: ________________

THE FOLLOWING INFORMATION IS REQUIRED (MAY BE PRINTED, TYPED, OR STAMPED)

NAME: ___________________

OFFICE OR AGENCY: ___________________

ADDRESS: ___________________

TELEPHONE NUMBER: ___________________
TB SCREENING FORM

THIS TWO PAGE FORM IS ONLY TO BE FILLED OUT IF PATIENT HAS A:

POSITIVE PPD or POSITIVE IGRA BLOOD TEST

(QuantiFERON TB Gold or T-Spot)

(PROVIDER MUST ENSURE COMPLETION OF TWO PAGE TB SCREENING FORM)
A. SELF-ASSESSMENT  (TO BE COMPLETED BY PATIENT)

Name: Last:______________________ First:__________________ Middle:_______________Date of Birth: ___/___/___

Address: ________________________________________________________________________________________
Street Apt. #        City       State     Zip Code

Phone: (  )                    Home     Cellular Emergency Number
     ( )                    ( )                    ( )

1. Have you ever had a TB skin test? □ Yes □ No □ Don't know □ If Yes, when was it? ___/___/___
   What was the result? □ Positive □ Negative □ Don't know □ If positive, do you have documentation? □ Yes □ No
2. Have you ever had a TB IGRA Blood Test? □ Yes □ No □ Don't know □ If Yes, when was it? ___/___/___
   What was the result? □ Positive □ Negative □ Indeterminate □ If positive, do you have documentation? □ Yes □ No
3. Did you have a chest x-ray after your positive skin or IGRA Blood test? □ Yes □ No □ If Yes, when was it? ___/___/___
   Where was it? (e.g., name of hospital, health care provider, clinic)

4. Have you ever been told that you have TB? □ If so, when was it? ___/___/___
5. Have you ever been treated for TB infection or TB disease? □ Yes □ No
   Which medicines did you take? ________________________________
   How long were you on the treatment? __________________________

Please place a √ mark in one of the columns to the right

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<th>Yes</th>
<th>No</th>
<th>Don't Know</th>
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<tr>
<td>6. Have you ever been told, or suspected, that you were exposed to someone with TB?</td>
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</table>
> If yes, when: ___/___/___ Name /Relationship: ____________________________
| 7. Have you ever had cancer of the head, neck or lung; leukemia; or lymphoma? |
| 8. Have you ever had an organ or tissue transplant? |
| 9. Are you taking steroids (like prednisone), chemotherapy or drugs that affect your immune system? |
| 10. Do you have diabetes or high blood sugar? |
| 11. Do you have any of the following symptoms: |
> • Cough longer than 2 weeks? If yes, date you first noticed ___/___/___
> • Fever, chills, night sweats longer than 2 weeks? If yes, date you first noticed ___/___/___
> • Weight loss that was not planned? If yes, date you first noticed ___/___/___
| 12. Do you have renal failure, or are you on kidney dialysis? |
| 13. Do you think you are at risk of having HIV infection? |
| 14. Have you ever injected street drugs? |
| 15. Were you born outside of the United States? If yes, what country? ____________________________ |
| 16. (If patient under 18) Has anyone who lives with you moved to the U.S. within the last 5 years? |
> If so, from which country? ____________________________
| 17. Have you had any visitors from outside the U.S.? When? ____________________________|
> Where were they from? ____________________________
| 18. Have you traveled to any other countries recently? Where? |
> How long did you stay? ____________________________
| 19. Have you ever lived or worked in a group setting such as a hospital, nursing home, drug treatment center, homeless shelter, jail, or prison? |

If you answered “Yes” to any of the questions from 5 to 18, you may be at increased risk of having TB infection or developing active TB. If you answered “No” to all, you are not considered at higher risk for TB.

Patient Signature
**TODAY'S DATE:** ____/____/____

**PATIENT'S NAME:** ___________________________________________  **D.O.B.:** / / __

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**B. ASSESSMENT OUTCOME AND TB TEST ADMINISTRATION (TO BE COMPLETED BY CLINICIAN)**

- [ ] Prior Documentation (or convincing history) of TB or LTBI:
  
  No TB test needed. **Patient may still need evaluation for treatment for LTBI or active TB.**

---

**TB Risk Category (check one box only):**

- [ ] Medical risk factor (includes contacts to active TB cases) (questions 6-13)
- [ ] Population risk factor (questions 14-19)
- [ ] Administrative (TB test required only for work, school, etc.)

---

**PHYSICAL EXAM:** Date: ___/___/___  
- [ ] No signs of TB  
- [ ] Abnormal, Suggesting TB

**CHEST X-RAY:** Date: ___/___/___  
[Must attach copy of impression summary]

---

**OUTCOME (check one box only):**

- [ ] LTBI treatment prescribed
- [ ] No treatment needed (Not infected)
- [ ] No treatment indicated (Low TB risk)
- [ ] Treatment deferred due to ___________________
- [ ] Patient being evaluated as a TB suspect
- [ ] Patient refused treatment
- [ ] Treatment not advised due to high risk of hepatitis
- [ ] Previously treated for TB or LTBI
- [ ] Other ___________________________________________________________________

**Follow-up/Comments (include treatment regimen):**

________________________________________________________________________

________________________________________________________________________

---

**SIGNATURE OF EXAMINING CERTIFIED NURSE PRACTITIONER OR PHYSICIAN:** ______________________

(Stamp is not acceptable in place of signature)

**DATE:** ______________________

The following information is required (may be printed, typed, or stamped)

**NAME:** ______________________

**OFFICE OR AGENCY:** ______________________

**ADDRESS:** ______________________

**TELEPHONE NUMBER:** ______________________

---

Developed by NYC Bureau of Tuberculosis Control, March 2006

2016/MC
TITER DOCUMENTATION

THIS SECTION IS TO BE COMPLETED BY PATIENT

CURRENT SEMESTER: FALL SPRING SUMMER YEAR:

PACE ID#: U____ Date of Birth: ____/____/____

LAST NAME: ___________________ FIRST NAME: ___________________

PHONE# (HOME): __________ (CELL): __________ (WORK): __________

I HEREBY AUTHORIZE PACE UNIVERSITY TO RELEASE ANY INFORMATION BELOW TO ANY HEALTH CARE PROVIDER WHICH MAY REQUIRE SAME IN CONNECTION WITH MY PARTICIPATION IN A CLINICAL COURSE. I UNDERSTAND THE AGENCY TO WHICH I AM ASSIGNED MAY REQUIRE MORE HEALTH DATA THAN LISTED BELOW.

PATIENT SIGNATURE: ___________________ DATE: ________

ALL 5 SECTIONS BELOW MUST BE COMPLETED BY HEALTH CARE PROVIDER

ALL DATES AND NUMERICAL RESULTS MUST BE DOCUMENTED ON THIS FORM. PLEASE CHECK ONE: “IMMUNE” OR “NON-IMMUNE”, OR WHERE APPLICABLE: “REACTIVE” OR “NON-REACTIVE”. IF NUMERICAL RESULTS ARE NOT AVAILABLE, LAB RESULTS MUST ALSO BE ATTACHED.

SECTION 1: RUBEOLA (MEASLES) TITER

DATE DRAWN: ______________ NUMERICAL RESULT: ______________

☐ IMMUNE ☐ NON-IMMUNE

[Individuals are not permitted in the clinical setting without a titer showing immunity. Individuals with non-immunity to MMR must be re-immunized and a new titer drawn 4-8 weeks later. Immunization must be documented on separate Lienhard School of Nursing MMR Non-Immune Titer Booster Documentation form]

SECTION 2: MUMPS TITER

DATE DRAWN: ______________ NUMERICAL RESULT: ______________

☐ IMMUNE ☐ NON-IMMUNE

SECTION 3: RUBELLA (GERMAN MEASLES) TITER

DATE DRAWN: ______________ NUMERICAL RESULT: ______________

☐ IMMUNE ☐ NON-IMMUNE

[If Varicella Titer does not show immunity, two varicella boosters are required (at least one month apart). Immunizations must be documented on separate Lienhard School of Nursing Varicella Booster form]

SECTION 4: VARICELLA (CHICKEN POX) IgG AB TITER

DATE DRAWN: ______________ NUMERICAL RESULT: ______________

☐ IMMUNE ☐ NON-IMMUNE

SECTION 5: HEPATITIS B SURFACE ANTIBODY TITER

DATE DRAWN: ______________

☐ REACTIVE ☐ NON-REACTIVE

[If Hepatitis B Titer does not show immunity, immunization is strongly recommended. Individuals who do not wish to be immunized or who are undergoing immunization process are required to complete the Hepatitis B Declination form]

I FIND HIM/HER TO BE IN GOOD HEALTH. HE/SHE IS FREE FROM A HEALTH IMPAIRMENT WHICH MAY POSE POTENTIAL RISK TO PATIENTS OR PERSONNEL, OR WHICH MAY INTERFERE WITH THE PERFORMANCE OF NURSING RESPONSIBILITIES. HABITUATIONS TO ALCOHOL OR OTHER DRUGS WHICH MAY ALTER THE INDIVIDUAL’S BEHAVIOR HAS BEEN CONSIDERED IN THIS EVALUATION.

MY SIGNATURE INDICATES THE INDIVIDUAL IS ABLE TO FULLY PARTICIPATE IN NURSING PRACTICE.

SIGNATURE OF EXAMINING CERTIFIED NURSE PRACTITIONER OR PHYSICIAN: ___________________

(STAMP IS NOT ACCEPTABLE IN PLACE OF SIGNATURE)

DATE: ______________

THE FOLLOWING INFORMATION IS REQUIRED (MAY BE PRINTED, TYPED, OR STAMPED)

NAME: ___________________

OFFICE OR AGENCY: ___________________

ADDRESS: ___________________

TELEPHONE NUMBER: ___________________

2016/MC
I understand that due to my occupational exposure to potentially infectious diseases, I may be at risk of acquiring measles, mumps, or rubella infection until my titer indicates I am immune. I have been informed of the potential risks to myself and the potential to infect others if I develop the disease(s). I have been informed that I must be boosted with the MMR vaccine.

- **Administered Date of MMR Booster:**
  
  [New MMR titer(s) must be drawn 4-8 weeks from this date]

- **Post MMR Titer(s) Drawn:**
  
  [Only select the titers that apply]

- **Date of Post MMR Titer(s):**

- **Numerical Result(s):**

- **Please Check One:**

  - Immune
  - Non-immune

  - Immune
  - Non-immune

  - Immune
  - Non-immune

  Copy of lab report(s) for post MMR titer(s) must also be attached

**Signature of Examining Certified Nurse Practitioner or Physician:**

(Stamp is not acceptable in place of signature)

**Date:**

The following information is required (may be printed, typed, or stamped)

**Name:**

**Office or Agency:**

**Address:**

**Telephone Number:**
VARICELLA (CHICKEN POX) BOOSTER FORM

__________________________  ________________________
Patient Full Name [Print]  Date of Birth

__________________________  ________________________
Patient Signature  Date

[Step 1] ○ I AM IN THE PROCESS OF RECEIVING IMMUNIZATIONS FOR VARICELLA WHICH STARTED ON:

[Must Enter Booster Date #1 here]

AND I UNDERSTAND THAT I MUST BE IMMUNIZED WITH A SECOND VARICELLA BOOSTER IN AT LEAST 1 MONTH. I UNDERSTAND THAT I CONTINUE TO BE SUSCEPTIBLE TO VARICELLA UNTIL VACCINATION PROCEDURES ARE COMPLETED. I WILL NOTIFY THE LIENHARD SCHOOL OF NURSING UPON COMPLETION OF THE VACCINATION SERIES.

[Step 2] ○ I HAVE BEEN IMMUNIZED WITH THE SECOND VARICELLA BOOSTER ON THE FOLLOWING DATE:

[Must Enter Booster Date #2 here]

I COMPLETED THE SERIES OF TWO VARICELLA IMMUNIZATIONS.

______________________________
Signature of Examining Certified Nurse Practitioner or Physician:

(Stamp is not acceptable in place of signature)

__________________________
Date:

THE FOLLOWING INFORMATION IS REQUIRED (MAY BE PRINTED, TYPED, OR STAMPED)

NAME: ____________________________________________

OFFICE OR AGENCY: ________________________________

ADDRESS: _______________________________________

TELEPHONE NUMBER: ______________________________
HEPATITIS B DECLINATION FORM

☐ I UNDERSTAND THAT DUE TO MY OCCUPATIONAL EXPOSURE TO BLOOD OR OTHER POTENTIALLY INFECTIONOUS MATERIALS, I MAY BE AT RISK OF ACQUIRING HEPATITIS B VIRUS (HBV) INFECTION. I HAVE BEEN INFORMED THAT I SHOULD BE VACCINATED WITH HEPATITIS B VACCINE. HOWEVER, I DECLINE HEPATITIS B VACCINATION AT THIS TIME. I UNDERSTAND THAT BY DECLINING THIS VACCINE, I CONTINUE TO BE AT RISK OF ACQUIRING HEPATITIS B, A SERIOUS DISEASE. IF, IN THE FUTURE, I CONTINUE TO HAVE OCCUPATIONAL EXPOSURE TO BLOOD OR OTHER POTENTIALLY INFECTIONOUS MATERIALS, AND I WANT TO BE VACCINATED WITH HEPATITIS B VACCINE, I WILL OBTAIN THE VACCINATION AND NOTIFY THE LIENHARD SCHOOL OF NURSING.

☐ I AM IN THE PROCESS OF RECEIVING IMMUNIZATIONS FOR HEPATITIS B WHICH STARTED ON: ___________________________ AND I UNDERSTAND THAT I CONTINUE TO HAVE OCCUPATIONAL EXPOSURE TO BLOOD OR OTHER POTENTIALLY INFECTIONOUS MATERIALS UNTIL VACCINATION PROCEDURES ARE COMPLETED.

☐ I HAVE COMPLETED THE SERIES OF HEPATITIS B VACCINES. I HAVE NOT HAD AN ANTIBODY TITER DRAWN AFTER THE SERIES. I UNDERSTAND THAT I MAY STILL BE AT RISK OF ACQUIRING HEPATITIS B (HBV) INFECTION.

☐ I HAVE COMPLETED THE SERIES OF HEPATITIS B VACCINES. I HAVE HAD POST-IMMUNIZATION HEPATITIS B SURFACE ANTIBODY TITER DRAWN ON: _______________________ AND MY RESULT WAS: ☐ REACTIVE ☐ NON-REACTIVE

SIGNATURE OF EXAMINING CERTIFIED NURSE PRACTITIONER OR PHYSICIAN: ________________________________

(STAMP IS NOT ACCEPTABLE IN PLACE OF SIGNATURE)

DATE: ________________________________

THE FOLLOWING INFORMATION IS REQUIRED (MAY BE PRINTED, TYPED, OR STAMPED)

NAME: ________________________________

OFFICE OR AGENCY: ________________________________

ADDRESS: ________________________________

TELEPHONE NUMBER: ________________________________

2016/MC
Below are some suggested companies that you can use for your CPR requirement:

(Both first time certification and re-certs available)

1) If you live in the city, Long Island or Queens:
CPR123’s website is: https://www.cpr123.com/courses-description/
Correct class to take: Basic Life Support for Healthcare Provider

2) HealthSav™ is an American Heart Association Training Center serving Rockland County, Westchester County, Orange & Putnam Counties, New York City with many Manhattan clients as well as many throughout New Jersey and Long Island.
Health Save USA - CPR classes can be found on their website: is http://healthsav.com/
Correct class to take: Basic Life Support for Healthcare Provider

For White Plains or Danbury, Connecticut:

3) http://cprdave.com/cpr-firstaid-courses/basic-life-support-healthcare-provider-certification/
Correct class to take: Basic Life Support (BLS) Healthcare Provider CPR

4) http://cpred.com/ (Brewster, NY)
Correct class to take: Basic Life Support (BLS) for Healthcare Providers

Either NYC or Westchester:

5) Classes can be found on the NY Red Cross website:
http://www.nyredcross.org/?nd=db_registration_event_manager
Correct class to take: CPR/AED for Professional Rescuers and Health Care Providers

6) Classes can be found on the American Heart Association website:
http://www.heart.org/HEARTORG/CPRAndECC/FindaCourse/Find-a-Course_UCM_303220_SubHomePage.jsp
Correct class to take: Basic Life Support for Healthcare Provider
## INFLUENZA VACCINATION FORM

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<th>Patient Full Name [Print]</th>
<th>Date of Birth</th>
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<table>
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<tr>
<th>Patient Signature</th>
<th>Date</th>
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**ALL ITEMS BELOW MUST BE COMPLETED BY HEALTH CARE PROVIDER**

### SEASONAL INFLUENZA VACCINATION

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<tr>
<th>Vaccine Lot #</th>
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**ADDITIONAL COMMENTS OR OTHER INFORMATION MAY BE ENTERED HERE**

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**SIGNATURE OF EXAMINING CERTIFIED NURSE PRACTITIONER OR PHYSICIAN:** __________________________

(Stamp is NOT acceptable in place of signature)

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**THE FOLLOWING INFORMATION IS REQUIRED (MAY BE PRINTED, TYPED, OR STAMPED)**

**NAME:** __________________________

**Office or Agency:** __________________________

**Address:** __________________________

**Telephone Number:** __________________________
Guidance for medical exemptions for influenza vaccination can be obtained from the contraindications, indications, and precautions described by the most recent recommendations of the Advisory Committee on Immunization Practices (ACIP) available in the Centers for Disease Control and Prevention publication, Morbidity and Mortality Weekly Report. They can be found at the following website, http://www.cdc.gov/vaccines/pubs/ACIP-list.htm.

Contraindications are conditions that indicate when vaccines should not be given. A contraindication is a condition that increases the chance of a serious adverse reaction. A precaution is a condition that might increase the chance or severity of an adverse reaction or compromise the ability of a vaccine to produce immunity. An indication is a condition that increases the chance of serious complications due to influenza infection. If an individual has an indication for influenza vaccination, it is recommended that they be immunized.

The following are not considered contraindications to influenza vaccination.

- Minor acute illness (e.g., diarrhea and minor upper respiratory tract illnesses, including otitis media).
- Mild to moderate local reactions and/or low-grade or moderate fever following a prior dose of the vaccine.
- Sensitivity to a vaccine component (e.g., upset stomach, soreness, redness, itching, swelling at the injection site).
- Current antimicrobial therapy (taking prescription anti-influenza therapy is only a temporary contraindication for the live attenuated influenza vaccine [LAIV]).
- Disease exposure or convalescence.
- Pregnant or immunosuppressed person in the household.
- Breast feeding.
- Family history (unrelated to immunosuppression).
- Any condition which is itself an indication for influenza vaccination.

Contraindications and precautions to all influenza vaccines include the following.

- Severe allergic reaction after a previous dose or to a vaccine component (e.g., eggs).*
- History of Guillain Barré Syndrome.
- Current moderate or severe acute illness with or without fever (until symptoms have abated).

* A severe allergic reaction is characterized by a sudden or gradual onset of generalized itching, erythema (redness), or urticaria (hives); angioedema (swelling of the lips, face or throat); severe bronchospasm (wheezing); shortness of breath; shock; abdominal cramping; or cardiovascular collapse.

Please document the patient’s contraindication/precaution here:

Date exemption ends (only if applicable):

A New York State licensed physician, physician assistant, nurse practitioner, nurse-midwife or licensed midwife must complete this medical exemption statement and provide their information below.

Name (print) ______________________________ NYS Medical License # ____________________

Address __________________________________ Telephone ___________________________

Signature __________________________________ Date __________________________

For Facility Use Only

Medical Exemption Status: [ ] Accepted [ ] Not Accepted Date __________________________

Reason:

DOH-4482 (10/10)
CLEARANCE REQUIREMENTS AND PROCESS FOR CLINICAL COURSES

Prior to attending a clinical course students must satisfactorily complete all clearance requirements for the Lienhard School of Nursing Department of Graduate Studies, and for each clinical agency where the student is being assigned to complete clinical hours to meet program requirements.

Clearance requirements for clinical courses include but are not limited to:

- Health Clearance,
- Proof of New York State, Registered Nurse License and current unrestricted registration, which must remain current and unrestricted until all program requirements are met and the student's degree is conferred
- Cardio Pulmonary Resuscitation with AED
- Mandatory Training
- Clinical Agency requirements may include but is not limited to: mandated drug screening, background check, respirator mask fit test, student interview, or facility orientation. Failure to satisfy agency requirements may result in student removal from the clinical site, reassignment of the clinical site and subsequent delay in program progression and completion

HEALTH CLEARANCE

All students are required to have adequate health insurance. Students are responsible for their own health care while in school. Selected clinical agencies may require evidence of health insurance. If you are placed at such an agency, it will be necessary for you to provide this evidence. If a health condition arises during the course of study that would in any way alter student's ability to perform in the clinical setting, it is the student's responsibility to notify the Director of the program in which they are enrolled.

Preparation for the clinical experience begins up to six months prior to the start of clinical courses to ensure that all health standards have been met. The completed health clearance process must demonstrate to the satisfaction of the Lienhard School of Nursing and any applicable clinical agency that all requisite health standards have been met.

The health clearance process consists of completing (i) the Annual Health Assessment Form (to be completed yearly); (ii) the forms pertaining to titer tests and immunizations (required only once); and (iii) any supplemental forms required by the agency(s) at which the clinical component of a course will be conducted. In addition, students are required to provide evidence of an annual influenza immunization. For the fall semester, the health clearance process must be completed by May 1; and for the spring semester, by August 1, unless otherwise instructed.

The required health forms are posted for students in the LSN Blackboard Community, and it is the student's responsibility to obtain these forms, and submit completed forms as directed. Students are required to upload and manage the required documents to an account they will subscribe to with American Databank. Separate instructions on how to open and upload the documents are posted in the LSN Blackboard Community. The registration of students who do not complete the health clearance process as required will be voided, and tuition cancellations, if any, will be made in accordance with the University's Tuition Cancellation Policy.

Health clearance must be maintained throughout the semester in which the student is enrolled in a clinical course. Students must notify the clinical faculty member and the course coordinator of any health condition that occurs during the semester that, if it had been detected during the health clearance process, would have resulted in the student being denied health clearance. In such cases, the student will not be permitted to attend clinical courses until he or she has been cleared to do so.

In addition to the health clearance required in order to participate in a clinical course, all students must, as required by New York State law, be immunized against measles, mumps and rubella. The registration of students who do not provide proof of the required immunization to the Office of Student Assistance will be voided. Clinical agencies may require additional immunizations before students are cleared to commence a clinical placement. Students are urged to keep copies of all health forms for their personal records.

Revised September 1, 2015

Criminal Background Checks and Drug Screening

There are various laws, standards and employer policies that require all employees, volunteers and students working in or assigned to a clinical site to undergo a criminal background check, and/or drug screening. Therefore, to comply with the Clearance Requirements for Clinical Placements, based on a clinical agency's requirement a student, at their own cost, may be required to complete a background check and/or drug screen to
secure the placement. Based on the agency requirement the student will either be directed to the agency to complete the agency’s required background check and/or drug screening, or the student will complete the background check and/or drug screening through Certified Background

Applicants and students should be aware that based on certain criminal convictions clinical affiliates may not accept a student for a clinical assignment or may rescind a previous acceptance. In such an event, and depending on the circumstances, the student may be unable to complete a required clinical experience and consequently the program curriculum requirements. Students who are unable to complete the program curriculum requirements are subject to dismissal from the program.

In addition, certain criminal convictions may result in the denial of the credentials needed to practice. Prospective students who are concerned about a criminal conviction are urged to contact the relevant state and/or federal agencies to inquire whether their criminal record may adversely affect the issuance of the credentials needed to practice as an advanced practice nurse practitioner. Further, certain criminal convictions may result in the LSN being required to the information to the New York State Division of Professional Licensing.

September 1, 2015

**LICENSURE AS REGISTERED PROFESSIONAL NURSE**

Prior to attending a clinical course, graduate students in the Lienhard School of Nursing must provide evidence they are currently licensed by the New York State Department of Education as a registered professional nurse and have a current unrestricted registration. In addition, graduate students must provide evidence they are currently licensed as a registered professional nurse and have a current unrestricted registration by any state in which a clinical site at which they have been placed is located. Information about New York State licensing requirements for a registered professional nurse may be found at [http://www.op.nysed.gov/prof/nurse/nursing.htm](http://www.op.nysed.gov/prof/nurse/nursing.htm) and [http://www.op.nysed.gov/prof/nurse/np.htm](http://www.op.nysed.gov/prof/nurse/np.htm).

Revised September 1, 2015

**CARDIOPULMONARY RESUSCITATION CERTIFICATION**

Every Lienhard School of Nursing student must submit evidence of professional rescuer CPR certification annually to the Lienhard School of Nursing on the Pleasantville campus. Certification must be by the American Red Cross or the American Heart Association in basic life support for the healthcare provider and include use of the AED (automated external defibrillator) on the adult, child, and infant.

Revised September 1, 2013

**MANDATORY TRAINING**

In order to participate in clinical placements Lienhard School of Nursing graduate students must have completed the following training.

- Occupational safety and health measures to reduce the transmission of bloodborne pathogens.

- The protection and disclosure of protected health information as defined by the federal Health Insurance Portability and Accountability Act (“HIPAA”).

- Practices and controls to prevent the transmission of the human immunodeficiency virus (“HIV”) and the hepatitis B virus.

- Identification and reporting of child abuse and maltreatment.

Further, a clinical agency may require students to participate in additional training before permitting them to commence a clinical placement. Questions about mandatory training should be addressed to the Lienhard School of Nursing Office of Academic Affairs.

Revised September 1, 2011