WESTERN CONNECTICUT STATE UNIVERSITY
DEPARTMENT OF NURSING

RN AND GRADUATE NURSING STUDENTS

Directions for Students,
The following forms attached must be completed and returned to the appropriate Department or uploaded to CastleBRanch:

1. Clinical credentialing Forms – page 2, must be completed and returned to the Department of Nursing (White Hall 107).

2. Tuberculosis (TB) Screening Form – page 3, must be completed by your Health Care provider and signed by you.

3. Students to keep copy of all materials for their records.

Requirements must be completed by

August 15th for Fall clinical and

January 15th for Spring clinical

Updated 9/12/18
WESTERN CONNECTICUT STATE UNIVERSITY
DEPARTMENT OF NURSING
Clinical Credentialing Form

Directions for RN and Graduate Nursing Students:
The following requirements pertain only to RN and Graduate nursing students AND are required for
WCSU clinical placements. Students will not be allowed to start their clinical area experience until this
credentialing process is complete.
The student is responsible for providing all written documentation listed below and this form must be
return initialed and signed to the Department Chairperson (Nursing) in White Hall room 107.
Please indicate by placing your initials next to each item listed below that you acknowledge receipt, and
agree to all stipulations identified in each document below:

<table>
<thead>
<tr>
<th>Student Initials</th>
<th>Document</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>PPD within last 12 months</td>
</tr>
<tr>
<td>2.</td>
<td>Copy of Current CPR Card (attach to this form and return to Dept. of Nursing)</td>
</tr>
<tr>
<td>3.</td>
<td>Maintain Comprehensive Health Insurance</td>
</tr>
<tr>
<td>4.</td>
<td>I (student) attest that I have never been convicted of a criminal offense related to health care and/or related to the provision of service paid for by Medicare, Medicaid, or another federal health care program; (b) excluded from participation in any federal health care program, including Medicare and Medicaid or (c) the subject of disciplinary action resulting in revocation or suspension of any license, certification, permit or other approval necessary to perform in a health care agency.</td>
</tr>
<tr>
<td>5.</td>
<td>I (student) attest that I have received complete health clearance.</td>
</tr>
</tbody>
</table>

STATEMENT OF RELEASE
Students who fail to provide written documentation that they have met the above stated requirements will
not be allowed in the clinical areas. A criminal background check may be required prior to placement in a
clinical assignment, direct cost to be incurred by the students. In certain circumstances, evidence of a
criminal record may prevent a student from fulfilling clinical requirements and/or requirements for
professional licensure.
I certify that I have complied with all health requirements and policies. I understand that by signing this
document that I accept all responsibility for having met all contractual health requirements by the
Department of Nursing, University, and agencies in which I may be assigned to do clinical. I certify that I have documentation of all the above and that I will produce such documentation at the request of the Nursing Department within 24 hours of such request. I understand that failure to meet and maintain clinical requirements will mean that I am not allowed into the clinical areas and I will not meet the program requirements.
I am aware that if during the course of the academic year(s) requiring my participation in clinical
experiences, my health status should change is a way that would impact my ability to perform in clinical; I
must notify the Director/Administrator of the nursing program and that the need for additional clearance
will be determined at that time.

PRINT NAME: _______________________________________________ and
SIGNATURE: _______________________________________________
DATE: ________________
TUBERCULOSIS (TB) SCREENING FORM

Name (Please print): Last: ___________________________ First: ______________________ Date of Birth: /____/____
Address: __________________________________________ State: __________ Zip Code: __________ Telephone: (____)______-_______

PLEASE CHECK “YES” OR “NO” FOR EACH QUESTION

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Have you ever had a positive tuberculosis test?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If so, did you have a chest x-ray?</td>
<td>Date:</td>
<td></td>
</tr>
<tr>
<td>Were you treated with medication?</td>
<td>How long?</td>
<td></td>
</tr>
<tr>
<td>2. Were you born in the United States?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If not, What country were you born in?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Have you traveled or lived outside of the U.S. for more than 3 months?</td>
<td></td>
<td></td>
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<tr>
<td>If so where?</td>
<td></td>
<td></td>
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<tr>
<td>4. Are you taking steroids, chemotherapy, radiation or drugs that affect your immune system?</td>
<td></td>
<td></td>
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<tr>
<td>5. Do you have any medical condition(s) that affect the immune system?</td>
<td></td>
<td></td>
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<tr>
<td>6. WOMEN: Is there any possibility that you are pregnant today?</td>
<td></td>
<td></td>
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<tr>
<td>7. Do you have any of the following symptoms:</td>
<td></td>
<td></td>
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<tr>
<td>Cough, Fever, chills; night sweats and/or weight loss longer than 2 weeks?</td>
<td></td>
<td></td>
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<tr>
<td>8. Have you received any “live” vaccines in the past 6 weeks, i.e. MMR, Varivax, Zoster or FluMist?</td>
<td></td>
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</tbody>
</table>

I hereby acknowledge that I have received and read the information sheet entitled “Tuberculosis and the Tuberculin Skin Test: What you Should Know, and I have had the opportunity to ask questions about the testing procedure. I understand that if the results of my TB test are positive, that I will need to follow-up with a healthcare provider.

Patient signature: ___________________________ Date: ___________________________

Mantoux Purified Protein Derivative (PPD) 5 test units (0.1 ml)

Tuberculin Product (Circle One): TUBERSOL or APLISOL
Lot Number: ___________________________ Expiration Date: /____/____

PPD #1 Date Planted: /____/____ Site: LEFT or RIGHT forearm
PPD #1 Date Read: /____/____ Result: ________mm POSITIVE NEGATIVE

Healthcare Provider Sign: ___________________________ Healthcare Provider Name: ___________________________ Title: ___________________________

DISPOSITION: _______________________________________________________

STUDENT to keep copy for your records (Rev 4/24/2013)