WESTERN CONNECTICUT STATE UNIVERSITY

DEPARTMENT OF NURSING

JUNIOR/SENIOR NURSING STUDENT

Directions for students.

The following items must be completed:

1. Access your existing Account https://login.castlebranch.com/login You need to continue to keep the information updated prior to the items/files expiring.

2. Keep a copy of all uploaded documentation for your records. Placement sites may request proof and you will be required to produce proof within 24 hours.

3. Do NOT click on the Student Fingerprint option. If fingerprinting is required, students will be notified by the Department of Nursing.

4. All nursing students are required to complete drug screening annually. Screening information will be provided by the Department of Nursing.

5. Background checks may need to be repeated. Information will be provided by the Department of Nursing.

It is your responsibility to make sure this information does not expire. You must be compliant before going to clinical.

Reviewed 6-29-2020
WESTERN CONNECTICUT STATE UNIVERSITY
DEPARTMENT OF NURSING
Clinical Credentialing Requirements

Directions for Junior and Senior Nursing Students:

The following requirements pertain only to junior and senior 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 obtaining and uploading all the required documentation to their account at https://login.castlebranch.com/login; inaccurate and/or incomplete documentation could impact the student's eligibility to participate in clinical.

<table>
<thead>
<tr>
<th>Student Check List</th>
<th>Document</th>
</tr>
</thead>
<tbody>
<tr>
<td>Renew Release Statement</td>
<td><strong>Must be uploaded each year</strong> (page 3 of packet)</td>
</tr>
<tr>
<td>Renew Technical Standards</td>
<td><strong>Must be uploaded each year</strong> (page 4 of packet)</td>
</tr>
<tr>
<td>Completed TB and PPD health screening form</td>
<td><strong>This is a yearly requirement</strong> Must be up to date to attend clinical (page 5 of packet)</td>
</tr>
<tr>
<td>Please check your T-Dap, it's good for 10 years only, must be current to go to clinical.</td>
<td></td>
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<tr>
<td>Physical Exam for Health Clearance (page 6 of packet)</td>
<td>Physical exam is good for 2 years.</td>
</tr>
<tr>
<td>The Nursing Student handbook must be reviewed, signed and uploaded to CastleBranch (page 7 of packet)</td>
<td></td>
</tr>
<tr>
<td>Current Healthcare Provider BLS CPR Card (i.e.: AHA or Red Cross) must be valid. ADULT, CHILD and INFANT, with DEFIBRILLATOR, Front &amp; Back, signatures must be visible.</td>
<td></td>
</tr>
<tr>
<td>Please note students will be also required to get a flu vaccination. The flu vaccination must be for the 2020-2021 season and it is usually available Sep/Oct 2020. You will receive an email from the Department of Nursing when flu vaccines are available and the date when it's due. <strong>Check your WCSU email during the summer</strong>. Proof must be uploaded.</td>
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</tbody>
</table>

In addition, the student needs Proof of Current Comprehensive Health Insurance. *It does not need to be uploaded, however, if asked to show proof student must show they are compliant.*

Failure to be compliant with updating CastleBranch may necessitate a Classroom/Lab/Clinical warning – you may also be withheld from clinical.
STATEMENT OF RELEASE

Students who fail to provide documentation that they have met the above stated requirements will not be allowed in the clinical areas. A criminal background check is 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) while participating in clinical experiences, I must notify the Nursing Department Chair and the Nursing Undergraduate Program Coordinator. I acknowledge that I may need additional clearance which would be determined at that time.

STUDENT PRINT NAME: ______________________

STUDENT SIGNATURE: ______________________ DATE: ________________
In order to be successful in the WCSU Nursing program, students must be able to meet the following technical standards and these standards must be continuously assessed. Students in the nursing program must have the ability and skills in the following domains: observational/communication ability, motor ability, intellectual/conceptual ability, and behavioral, interpersonal, and emotional ability. Students must be able to independently (with or without accommodation) meet the following technical standards:

Observation/Communication Ability – Nursing students must be able to:
- Effectively communicate both verbally and non-verbally with patients, peers, faculty, and other healthcare professionals
- Effectively use senses of vision, touch, hearing, and smell in order to interpret data
- Demonstrate abilities with speech, hearing, reading, writing, proficiency in English language, and computer literacy

Motor Ability – Nursing students must be able to:
- Perform gross and fine motor skills, physical endurance, strength, and mobility to carry out nursing procedures
- Demonstrate physical and mental stamina to meet demands associated with excessive periods of standing, moving, physical exertion, and sitting
- Demonstrate physical, cognitive and affective skills to perform and/or assist with procedures, treatments, administration of medications, operate medical equipment, and assist with patient care activities such as lifting, wheelchair guidance, and mobility

Intellectual/Conceptual Ability – Nursing students must be able to:
- Problem solve, measure, calculate, reason, analyze, and synthesize data in order to make decisions, often in a time urgent environment
- Incorporate, apply and synthesize new information from teachers, peers, and the nursing literature
- Interpret and respond appropriately to data from electronic and other monitoring devices

Behavioral, Interpersonal, and Emotional Ability – Nursing students must be able to:
- Tolerate physically taxing workloads and function effectively during stressful situations
- Display flexibility and adaptability in the work environment
- Function in cases of uncertainty that are inherent in clinical situations involving patients/clients
- Possess the skills required for full utilization of the student's intellectual abilities
- Exercise stable and sound reasoning in the clinical setting
- Establish rapport and maintain sensitive, interpersonal relationships with others from a variety of social, emotional, cultural, and intellectual backgrounds
- Accept and integrate constructive criticism given in the classroom and clinical setting

I (student) attest that I have read, understood, and agree that I am able to carry out the above mentioned Technical Standards.
HEALTH SERVICES: TUBERCULOSIS (TB) SCREENING FORM

Name (Please print): Last: _______________________________ First: ____________________________ Date of Birth: ___/___/___
Address: _____________________________________________________________________________________
City: ___________________________ State: _______ Zip Code: __________ Telephone: (__________) _______ - _____________

Please check "YES" or "NO" for each question

<table>
<thead>
<tr>
<th>Question</th>
<th>YES</th>
<th>NO</th>
</tr>
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<tbody>
<tr>
<td>1. Have you ever had a positive tuberculosis test?</td>
<td></td>
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<tr>
<td>If so, did you have a chest x-ray? Date: ___________________ Were you treated with medication?</td>
<td></td>
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<tr>
<td>How long? ___________________________________________ Did you ever receive BCG? _______________</td>
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<tr>
<td>Please provide proof of confirmed X-ray report, proof of treatment and MD Clearance.</td>
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<tr>
<td>2. Were you born in the United States?</td>
<td></td>
<td></td>
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<tr>
<td>If not, What country were you born in? _____________________________</td>
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<tr>
<td>3. Have you traveled or lived outside of the U.S. for more than 3 months?</td>
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<tr>
<td>If so where? _____________________________________________________________________________</td>
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<tr>
<td>4. Are you taking steroids, chemotherapy, radiation or drugs that affect your immune system?</td>
<td></td>
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<tr>
<td>5. Do you have any medical condition(s) that affect the immune system?</td>
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<tr>
<td>6. <strong>WOMEN</strong>: Is there any possibility that you are pregnant today?</td>
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<tr>
<td>7. Do you have any of the following symptoms:</td>
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<tr>
<td>Cough, Fever, chills; night sweats and /or weight loss longer than 2 weeks?</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>
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_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

Or QuantiFERon Gold Blood Test
Result: ______ Date__________
This test must be done if you have received BCG.
Healthcare Provider Sign: _______________ Healthcare Provider Name: _______________ Title: _______________

Healthcare Provider Sign: _______________ Healthcare Provider Name: _______________ Title: _______________

**DISPOSITION:**

STUDENT PRINT NAME: __________________________________________
STUDENT SIGNATURE: __________________________________________ DATE: __________
PHYSICAL EXAM FOR HEALTH CLEARANCE:
(Requires to be completed by Healthcare Provider to show proof of updated physical)

JUNIOR/SENIOR NURSING STUDENT: __________________________________________________________

On the basis of my health assessment and physical examination the above nursing student is free of communicable diseases and is cleared to participate in all clinical nursing activities without restrictions (please circle)   Yes   No

IF NO, please explain the nature of the restrictions/limitations related to the delivery of patient care:

____________________________________________________________________________________________________________________________
____________________________________________________________________________________________________________________________
____________________________________________________________________________________________________________________________

Date of Physical Examination: ___________   Is The Student Allergic To Latex?   Yes   No

Today's Date: __________________________

Healthcare Provider Signature: _________________________________________________

Healthcare Provider Name/Title: ______________________________________________

License Number: __________________________________________________________________

Office Address: __________________________________________________________________

Office Telephone: __________________________________________________________________

Please note that the physical exam cannot be more than two years old.
Western Connecticut State University
Department of Nursing


Please print your name clearly _________________________________

Signature ________________________________________________

Date _______________