

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://discover.castlebranch.com/> Items must be updated prior to expiring. Noncompliance will result in a written warning.
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 30 days prior to clinical. Screening information will be provided through CastleBranch.
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. Those that expire, are rejected or overdue will have a clinical warning issued and may be removed from class/clinical.

**WESTERN CONNECTICUT STATE UNIVERSITY
DEPARTMENT OF NURSING
Clinical Credentialing Requirements**

Directions for **Junior and Senior** Nursing Students:

The student is responsible for obtaining and uploading all the required documentation to their account at <https://discover.castlebranch.com/>; inaccurate and/or incomplete documentation could impact the student's eligibility to participate in clinical and a warning issued.

Student Check List	Document
<input type="checkbox"/>	Renew Release Statement <i>Must be uploaded each year</i> (page 3 of packet)
<input type="checkbox"/>	Renew Technical Standards <i>Must be uploaded each year</i> (page 4 of packet)
<input type="checkbox"/>	Completed TB and PPD health screening form If going to Northwell Health an initial 2 step PPD or Quantiferon Gold Blood Test is required, then annually thereafter. (page 5 of packet)
<input type="checkbox"/>	Please check your T-Dap (every 10 years), Covid Vaccination.
<input type="checkbox"/>	Physical Exam (yearly) for Health Clearance (page 6 of packet)
<input type="checkbox"/>	Hepatitis B (series of three vaccinations and a positive titer or declination letter).
<input type="checkbox"/>	Review the Nursing Student Handbook (page 7 of packet)
<input type="checkbox"/>	CHA Test – print, complete and uploaded to CastleBranch, making sure pages are in order. Test included in packet or at https://cthosp.org/webfoo/wp-content/uploads/Health-and-Safety-Course-Test.pdf .
<input type="checkbox"/>	Current CPR card (i.e.: American Heart Association - Health Care Professionals Basic Life Support OR American Red Cross - Professional Rescuer) must be valid. Including: <u>ADULT</u> , <u>CHILD</u> and <u>INFANT</u> , with DEFIBRILLATOR. Front & Back signatures must be visible.
<input type="checkbox"/>	Please note students will be also required to get a flu vaccination. The flu (2025-2026) vaccination must be for the current season by 10/15/2025. You will receive an email from the Department of Nursing when flu vaccines are available and the date when it's due. Check your WCSU email during the summer and all of your breaks. Proof must be uploaded.

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DEPARTMENT OF NURSING

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 and drug testing are 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, **If my health status should change in a way that would impact my ability to perform in clinical, I am required to 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:** _____

Western Connecticut State University
Department of Nursing
Technical Standards**

In order to be successful in the Western CT State University Nursing program, students should be aware that the ability to meet the following technical standards is continuously assessed. Students in the nursing program need the ability and skills in the following domains:

- observational communication ability,
- motor ability,
- intellectual/conceptual ability,
- behavioral, interpersonal, and emotional ability.

Students must be able to perform independently, with or without accommodation, to 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
- use senses of vision, touch, hearing, and smell in order to interpret data
- demonstrate abilities with speech, hearing, reading, writing, English language, and computer literacy

Motor Ability – Nursing students must be able to:

- display gross and fine motor skills, physical endurance, strength, and mobility to carry out nursing procedures
- possess physical and mental stamina to meet demands associated with excessive periods of standing, moving, physical exertion, and sitting
- 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 new information from teachers, peers, and the nursing literature
- interpret 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, sound judgment
- 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.

STUDENT PRINT NAME: _____

STUDENT SIGNATURE: _____ **DATE:** _____

*Approved: Student Committee DON 2/1/2010; Faculty 2/3/2010 **Adopted from SCSU Dept. of NUR Technical Standards Reviewed: 11/13/21*



WESTERN CONNECTICUT STATE UNIVERSITY

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	YES	NO
1. Have you ever had a positive tuberculosis test? If so, did you have a chest x-ray? _____ Date: _____ Were you treated with medication? _____ How long? _____ Did you ever receive BCG? _____ Please provide proof of confirmed X-ray report, proof of treatment and MD Clearance.	<input type="checkbox"/>	<input type="checkbox"/>
2. Were you born in the United States? If not, What country were you born in? _____	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you traveled or lived outside of the U.S. for more than 3 months? If so where? _____	<input type="checkbox"/>	<input type="checkbox"/>
4. Are you taking steroids, chemotherapy, radiation or drugs that affect your Immune system?	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have any medical condition(s) that affect the immune system?	<input type="checkbox"/>	<input type="checkbox"/>
6. WOMEN: Is there any possibility that you are pregnant today?	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you have any of the following symptoms: Cough, Fever, chills; night sweats and /or weight loss longer than 2 weeks?	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you received any 'live' vaccines in the past 6 weeks, i.e. MMR, Varivax, Zoster or FluMist)?	<input type="checkbox"/>	<input type="checkbox"/>
<i>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.</i>		

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

Result _____ mm

PPD #1 Date Read: ____/____/____

POSITIVE NEGATIVE

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

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

PPD #2 Date Planted: ____/____/____

Site: LEFT or RIGHT forearm

Result _____ mm

PPD #2 Date Read: ____/____/____

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: _____

DISPOSITION: _____

Student Sign: _____

Student Print Name: _____ DATE: _____

Western CT State University
Department of Nursing

PHYSICAL EXAM FOR HEALTH CLEARANCE:
*(Needs 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 one year old.

Western Connecticut State University
Department of Nursing

This is an attestation that I have accessed read the Nursing Student Handbook online at <https://www.wcsu.edu/nursing/wp-content/uploads/sites/77/2025/03/Nursing-Student-Handbook-3-5-25-FINAL-1.pdf>

Please print your name clearly _____

Signature _____

Date _____