WESTERN CONNECTICUT STATE UNIVERSITY
DEPARTMENT OF NURSING

ADVANCED PRACTICE NURSING STUDENTS

Directions for Students,
The following forms attached must be completed and uploaded to CastleBranch:

1. **Clinical credentialing Forms – page 2, must be uploaded to CastleBranch.**
2. **Tuberculosis (TB) Screening Form – page 3, must be completed by your Health Care provider, signed by you and uploaded to CastleBranch.**
3. **Health Physical Exam Clearance – page 4, physical yearly and must be signed by a provider and uploaded to CastleBranch.**
4. **Students to keep copy of all materials for their records.**
5. **Student is accountable for updating CastleBranch. Contact Graduate Clinical Placement Coordinator for information with CastleBranch.**

Requirements must be completed by

June 1st for Fall clinical and

January 15th for Spring clinical

Updated 08/06/26

WESTERN CONNECTICUT STATE UNIVERSITY
DEPARTMENT OF NURSING
Clinical Credentialing Form

Directions for Advanced Practice Nursing Students

The following requirements pertain only to Advanced Practice 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. Students must keep up to date and cannot let items expire. The student is responsible for uploading to their CastleBranch Account: (https://discover.castlebranch.com/) .

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:

Student Initials	Document
1.	Vaccine Records: Proof of titers Draws (i.e.: Lab Report.) T-Dap (valid for 10 years) MMR (2 vaccines) Varicella (X2 or proof of positive titer) Hepatitis B (series of three vaccinations and a positive titer or declination waiver). Physical cannot be more than one year old. If going to Northwell Health an initial 2 step PPD or Quantiferon Gold Blood Test is required 3 months before start date, then 1 step or Quantiferon Gold Blood Test annually. COVID vaccination. Annual influenza vaccination.
2.	Copy of current Health Care Provider; Basic Life Support CPR, Adult, Infant & Child, Defibrillator. AHA & ARC.
3.	Maintain Comprehensive Health Insurance (must be able to provide of card if requested).
4.	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.
5.	I (student) attest that I have received complete health clearance, physical exam every year.
6.	Current copy of CT License.
7.	Background check.
8.	Drug testing 30 Days prior to start of clinical.

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, if my health status should change in 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.

STUDENT PRINT NAME: _____

STUDENT SIGNATURE: _____ DATE:_____

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, results, proof of treatment and MD clearance.		
2. Were you born in the United States? If not, What country were you born in? _____		
3. Have you traveled or lived outside of the U.S. for more than 3 Months? If so where? _____		
4. Are you taking steroids, chemotherapy, radiation or drugs that affect your Immune system?		
5. Do you have any medical condition(s) that affect the immune system?		
6. **WOMEN**: Is there any possibility that you are pregnant today?		
7. ***Do you have any of the following symptoms:*** Cough, Fever, chills; night sweats and /or weight loss longer than 2 weeks?		
8. Have you received any 'live' vaccines in the past 6 weeks, i.e. *MMR, Varivax, Zoster or FluMist)?*		

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**
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: _____

D I S P O S I T I O N: _____ _____ ___

Student Sign: _____

Student Print Name: _____ D ate: _____

Western Connecticut State University
Department of Nursing

HEALTH PHYSICAL EXAM CLEARANCE TO PARTICIPATE IN CLINICAL SETTING:

(Needs to be completed by Healthcare Provider to show proof of updated physical)

ADVANCED PRACTICE 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:

The student has been evaluated in accordance with OSHA Respirator Medical Evaluation Questionnaire. Based on a review of the medical questionnaire alone, this student is Cleared for Respirator Use:
(please circle) Yes No

IF NO, please explain:

Date of Physical Examination: _____ (PHYSICAL IS GOOD FOR 1 YEAR ONLY)

Is The Student Allergic To Latex? Yes No

Today's Date: _____

Healthcare Provider Signature: _____

Healthcare Provider Name/Title: _____

License Number: _____

Office Address: _____

Office Telephone: _____