Department of Nursing
A.A.S.

Student Packet

Fall 2016
Dear Nursing Student,

It is my pleasure to welcome you on behalf of the faculty and staff of the Nursing Program to Bergen Community College. I wish you success in your professional and personal goals. To that end, myself, the faculty, and staff are committed to assist you as you begin this incredible journey culminating in your entry into the profession of nursing.

This nursing program prepares its graduates to become leaders of tomorrow by integrating classroom content with real life patient interactions in a variety of healthcare facilities. The program uses cutting edge technology such as the Human Patient Simulator to provide simulated experiences. This amazing learning tool enables you to practice your clinical skills before embarking into the clinical areas.

Graduates of the Bergen Community College Nursing Program are sought after by every healthcare facility in the college’s service area. Graduates of the program consistently report that they “were extremely well prepared to begin their nursing career”. Other indicators of success are that the program is fully accredited by the National League for Nursing Accreditation Commission and the New Jersey Board of Nursing.

Your future begins here and now. Best wishes for success.

Sincerely,

Dawn Kozlowski, PhD, RN, CNE
Associate Dean of Nursing
NEW STUDENT ORIENTATION FOR FALL 2016 SEMESTER

June 15th, 16th, and 17th
8:30am-3:30pm
(June 17th session ends at 5:30pm)
Tec Building -- Room TEC-128

ATTENDANCE IS MANDATORY!!!
MANDATORY

NURSING DEPARTMENT REQUIREMENTS

Please read carefully and complete ALL requirements by the deadline listed. Students will not be permitted in classes, labs, or clinicals until all documentation has been received and all requirements have been met.

Deadline for all Requirements to be turned in: July 29, 2016 (NO Exceptions)

Nursing Department Requirements: (Instructions for each on following pages)

- Nursing: Health Professions Immunization Requirements Form (Measles, Mumps, Rubella and Varicella Titers, Tdap)

- BCC Health Services Department Requirements
  - Health Services Medical Record Form
  - Hepatitis B Surface Antibody Titer Acceptance/Declination Form
  - Tuberculosis (TB) 2-Step Screening Requirement Form
  - Recent Tdap Vaccine
  - Urine Drug Screening Form
  - Flu Vaccine
  - Copy of Health Medical Insurance Company card

- Malpractice Insurance (coverage as a Registered Nurse Student)
- CPR certification
- Student Handbook Sign-off Form
  Do not sign until you have read the Nursing Student Handbook. You can access the Handbook with the following link:

Documents (other than Health Services forms) may be dropped off in B301 during normal business hours, placed in a dropbox outside B301 or mailed to:

Bergen Community College
Darlene Zales-Russamano, Assistant Dean/Clinical Coordinator
400 Paramus Road
Paramus, NJ 07652
HEALTH SERVICES
IMMUNIZATION POLICY FOR ALL NURSING STUDENTS

This informational sheet is provided to assist you and your health provider with all the requirements that are now needed for all Nursing students as well as the Health Professions. Hopefully, this letter may clear up any questions you or your provider may have.

The attached forms must be completed and returned to the Health Services Office no later than July 29, 2016.

- **A recent physical form needs to be filled out by your provider.** The physical form cannot be older than 6 months.
- **Our clinical affiliate hospitals have imposed effectively immediately, the following requirements that affect the Health Professions and Nursing Students.**
  1. All Nursing and Health Profession students are required to have titers drawn for Measles (Rubeola), Mumps, Rubella, Varicella. Laboratory reports must be attached. If the test/titer is negative or equivocal you must be revaccinated.
  2. A Hepatitis B Surface Antibody blood titer. If the Hepatitis B titer is negative and you have proof that you did receive the vaccine, you can sign a declination (attached) if you want, but you must submit the three dates in the appropriate area as requested.
  3. A recent Tdap vaccine. (Please note that a TD, or Dtap is not in compliance.)
  4. Tuberculosis TB screening must be a 2-step. (Form is attached)
  5. Drug screening (A form is attached with specific requirements.)
  6. Copy of Health/Medical Insurance Company/Group Card. (If you do not have health insurance, you can purchase a limited policy thru the Bursars office. Please contact the Bursars office for more information)
  7. Flu vaccination documentation must be submitted.

Thank you,
The Center for Health Wellness and Personal Counseling
Room HS 100
NURSING AND HEALTH PROFESSIONS
IMMUNIZATION REQUIREMENT FORM

Email: _____________________________

Last Name (Please Print) / First / Middle initial (circle) / Student ID or Social Security #

Address: Street / City / State / Zip Code

Contact: Home: _____________________ Work: ___________________ Cell: ___________________ Date of Birth: ____________

PERSON TO BE NOTIFIED IN CASE OF EMERGENCY:
Name ____________________________________________________________________________________________________________
Contact Home: _____________________ Work: ___________________ Cell: ___________________

Part A: Student: Please answer all questions as completely as possible.

<table>
<thead>
<tr>
<th>Question</th>
<th>Y</th>
<th>N</th>
<th>Explain/List/Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Head injury/fainting/seizure?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Eye injury/loss of vision?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Broken bone?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Hospitalization or surgery?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Diabetes, Heart, Lung, Asthma, Cancer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Anxiety/emotional/mental illness?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Other health problems?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Allergies: food/medications/environmental</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Take any medications regularly?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Part B: Health Care Provider/Physician:
ALL Nursing and Health Profession students are required to have titers drawn for Measles (Rubeola), Mumps, Rubella, Varicella and Hepatitis B surface Antibody. Laboratory reports must be attached. If test/titer is negative or equivocal you must be revaccinated.

Measles (Rubeoia) IgG:  date drawn  IgG Titer Value  
☐ immune  
☐ not immune  
Revaccination date if titer is negative or equivocal

Mumps IgG:  date drawn  IgG Titer Value  
☐ immune  
☐ not immune  
Revaccination date if titer is negative or equivocal

Rubella  date drawn  IgG Titer Value  
☐ immune  
☐ not immune  
Revaccination date if titer is negative or equivocal

Hepatitis B Surface IgG Titer Value  
☐ immune  
☐ not immune  
Revaccination dates if titer is negative or signed declination

Antibody titer  date drawn  IgG Titer Value  
☐ immune  
☐ not immune  
Revaccination dates if titer is negative or equivocal

Varicella IgG  date drawn  IgG Titer Value  
☐ immune  
☐ not immune  
Revaccination dates if titer is negative or equivocal

Date of Tdap ________________ (Must be within 10 Years)

Tuberculosis TB Screening: 2 STEP required please see attached form.
Name of Health/Medical Insurance Company/Group ___________________________ (copy of card must be attached)

Signature: Health Care Professional/Physician: ____________________________ Date: ____________

Health Care Address & STAMP: ____________________________________________________________________________________
THIS MEDICAL EXAM MUST BE RETURNED TO HEALTH SERVICES BEFORE STARTING CLASSES. IF YOU ARE A NURSING AND HEALTH PROFESSIONS STUDENT, THIS MEDICAL EXAM MUST BE DATED, SIGNED AND STAMPED WITHIN 6 MONTHS OF STARTING YOUR PROGRAM IN ORDER TO BE CLEARED FOR CLINICAL.

Part C: Health Care Provider/Physician complete:

<table>
<thead>
<tr>
<th>Patient's Name:</th>
<th>Date of Birth</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address: Street</td>
<td>City</td>
<td>State</td>
</tr>
</tbody>
</table>

**Emergency Contact:**

- **Name:**
- **Telephone:**

- **Height:**
- **Weight:**
- **Blood/Pressure:**
- **Pulse:**
- **Respirations:**
- **Temp:**

**Review of Systems:**

<table>
<thead>
<tr>
<th>System</th>
<th>Norm</th>
<th>Abnor</th>
<th>Comments/Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skin</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Head, Ears, Nose, Throat</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Glands (cervical, axillary, inguinal)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eyes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chest</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lungs (chronic bronchitis, asthma)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart (murmurs, click, rhythm)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abdomen (Liver, spleen, masses)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metabolic/Endocrine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neurological/Neuropsychiatric</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Allergies** to food or medicines: (Please list)

**Medical condition(s)** requiring ongoing care:

**Clinical Impression** based on history and physical exam:

**MEDICATIONS:**

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Medication</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Recommendations:** For this student:

- May participate in physical activities
- Needs health problems evaluated prior to participation in physical activities
- Limit classroom and physical activities as follows:
- No participation due to:

**Comments or Recommendations:**

**Signature:** Health Care Professional/Physician:

**Date:**

**Health Care Address & STAMP:**

Please be advised that this information will not be shared. However there may be a time when our Professional Staff may need to confer with other campus Professionals or appropriate health care providers in the event of an emergency.

Rev 7/14
Incoming Nursing/Health Professions Students – Tuberculosis (TB) Screening Requirement

Part A must be completed by you. Part B must be completed by your physician or healthcare provider. Please return the completed form to The Office of Health Services, HS-100, Pitkin Education Center.

Part A

Name: ________________________________ Date of birth: ____________

Student ID: __________________________ Email address: __________________________

Home Phone: __________________________ Cell Phone: __________________________

Part B

Tuberculosis (TB) Screening: In order to be cleared for clinical participation, you are required to submit the date and results of either a 2-Step Mantoux Tuberculin Skin Test (TST) dated within 6 months of starting your program OR the results of an Interferon Gamma Release Assay (IGRA) blood test such as Quantiferon Gold dated within 6 months of starting your program.

Tuberculin Skin Test (TST) results:

TST(Mantoux) #1: ________ (date administered) ________ (date read- 48-72 hrs. after injection)

Results: positive ________ negative ________ (circle one); results must be documented in millimeters.

TST(Mantoux)#2: (administered a minimum of 7 days after TST#1 is read; 1-3 weeks is recommended interval.)

__________ (date administered) ________ (date read- 48-72 hrs. after injection)

Results: positive ________ negative ________ (circle one); results must be documented in millimeters.

OR

Results of the Quantiferon Gold blood test may be submitted in place of the 2-Step TST.

__________ (date of blood test) Result: positive ________ negative ________ (circle one) *Lab report of blood test must be attached*

Chest X-ray is required if PPD or Q-Gold result is positive. Chest X-ray must be performed within 6 months of starting your program. Chest X-ray report must be attached. *If result of the Q-Gold blood test is indeterminate, repeat Q-Gold or administer PPD skin test.*

Signature of physician or Healthcare Provider: __________________________ Date: __________

Healthcare Address Stamp:

Rev 4/13
Hepatitis B Vaccine Acceptance/Declination Form

Due to your occupational exposure to blood or other potentially infectious material (OPIM) you may be at risk of acquiring hepatitis B virus (HBV) infection. Hepatitis B vaccination is strongly recommended unless:

1) Documentation of prior vaccination and post-vaccination titer is provided to Health Services
2) Medical evaluation identifies that vaccination is contraindicated.

I understand that due to my occupational exposure to blood or OPIM I may be at risk of acquiring Hepatitis B virus

Declination Reason:

- I decline because I have received the 3-dose Hepatitis B vaccination in the past. List dates: _______, _______, _______ and send a copy of the vaccination record and post-vaccine titer*.
- I decline because I have evidence of immunity (send a copy of the antibody titer record*).
- Other reason for declination; explain: __________________________________________

*Send prior vaccination records and/or immunity records

______________________________________________                  ______________________________
Signature of Student                                     Date signed

______________________________________________
Students name (print)                                     ID #

______________________________________________
Program of Study
ATTENTION NURSING STUDENTS!!

URGENT MESSAGE

Effective IMMEDIATELY, OUR CLINICAL AFFILIATE Hospitals have a new requirement that MANDATES a URINE DRUG SCREENING.

LAB CORP IS THE ONLY ACCEPTABLE LAB TO COMPLETE THIS DRUG SCREENING. You must complete this screening in order to participate in all clinical education for FALL 2016 SEMESTER. The screening will cover clinical education for a 12 month period.

There are sites in Bergen, Hudson, and Passaic Counties, WHERE YOU CAN GO TO HAVE THE COLLECTIONS DONE. ONLY CREDIT/DEBIT CARDS OR MONEY ORDER WILL BE ACCEPTED. NO CASH or PERSONAL CHECKS WILL BE ACCEPTED. THE FEE IS $45. PLEASE SEE LOCATIONS LISTED BELOW:

464 Valley Brook Road, Lyndhurst, NJ Phone 201-672-0138 Mon-Fri 11 am – 2 pm.
170 Prospect Ave. Suite 201, Hackensack, NJ Phone 201-343-0222 Mon-Fri 11 am – 2 pm.
522 Central Ave. Jersey City, NJ Phone 201-659-0278 Mon-Fri 11 am -2 pm.
3196 Kennedy Blvd. 2ND floor, Union City NJ Phone 201-330-3274 Mon-Fri 11 am –2 pm.
209 Lefante Way, Bayonne, NJ Phone 201-436-0129 Mon-Fri 11 am- 2 pm.
1011 Clifton Ave. Suite 201, Clifton, NJ Phone 973-365-1186 Mon–Fri 11 am-2 pm.

You can also schedule an appointment on-line. The web site is WWW.LABCORP.COM.

YOU MUST BRING:

1. THE ATTACHED COLLECTION AUTHORIZATION FORM
2. A PHOTO ID CARD
3. A CREDIT/DEBIT CARD OR MONEY ORDER FOR $45.00. NO CASH OR PERSONAL CHECKS WILL BE ACCEPTED.

Results are sent directly to the Dean of Health Professions
This test must be completed by July 29, 2016 in order for the results to reach the college before clinical begin

REMINDER YOU MUST COMPLETE THIS Screening IN ORDER TO PARTICIPATE IN CLINICAL EDUCATION FOR THE FALL SEMESTER!!!
Donor Name: ____________________________________________

Attn Donor: Please present this authorization form to the collection site upon arrival. Make sure you have a photo ID, and a credit card to pay for the testing or a money order for the exact amount.

Attn Collector:

*************CASH SALES ACCOUNT ONLY*************
Collect $45 for urine test (765753-$30.00; 708008-$10.00; 708776-$5.00

*** Account Name: BERGEN COMMUNITY COLLEGE RM HS100
*** LabCorp Account # : 29032700 –HLTH PROFESSIONS COC ACCT
*** Test(s) To Be Performed (please check off):

☐ 765753 12+Oxycodone+Crt

*** REQUIRED FIELDS
• REASON FOR TEST: □ PRE-EMPLOYMENT □ RANDOM
• □REASONABLE SUSPICION/FOR CAUSE □POST ACCIDENT
• □PERIODIC □OTHER

Collection Site Locations (only):

Collector: If you have any questions, please contact:

Client Contact: Health Services Office 201-447-9257
OR

OTS Customer Operations: 800 833-3984 option #5
LabCorp Web COC Authorization Form Revised: 10/25/2009
Nursing students are required to purchase liability insurance. You can purchase the insurance from any company, but it must cover you as a Registered Nurse Student for at least the amounts of 1 million dollars ($1,000,000) per individual claim and 6 million dollars ($6,000,000) per aggregate claim.

Many of our nursing students use NSO (Nurses Service Organization) to purchase their liability insurance. This company’s liability coverage for nursing students is now at a level of $1,000,000 per individual claim and $6,000,000 per aggregate claim for a Registered Nurse Student. You can apply online to purchase your insurance from NSO at: www.nso.com or you can call toll free at 1-800-247-1500.

A copy of your Certificate of Insurance must be turned in with your other required paperwork by July 29, 2016.
ALL NURSING STUDENTS ARE REQUIRED TO MAINTAIN CPR CERTIFICATION FROM THE FOLLOWING ORGANIZATIONS ONLY:

**American Heart Association**
Level: BLS for Health Care Provider Certification

~ Or ~

**American Red Cross**
Level: CPR/AED for the Professional Rescuer and the Healthcare Provider Certification

*IMPORTANT:* Be sure you have registered for the correct level of CPR certification as indicated above. CPR certification must also be from a live, in-person course from either of the organizations listed above. No online CPR certification can be accepted.

Class schedules are available online at the American Heart Association website, [www.americanheart.org](http://www.americanheart.org) and the American Red Cross website, [www.redcross.org](http://www.redcross.org).

The Bergen Community College School of Continuing Education also offers CPR classes that meet our Nursing Department requirements. You can contact the Bergen Community College School of Continuing Education at 201-447-7488 to obtain more information.

It takes a few weeks to receive your official CPR card. **Upon receipt of your card, please make a photocopy of the card and submit it with your other required paperwork to the Nursing Office B 301 by July 29, 2016.** *If you have not received a copy of your card by July 29, 2016 – we will temporarily accept a letter from the CPR course instructor stating that you successfully passed the course (until your card arrives).*

*Students who are unable to meet the performance criteria for Certification due to health restrictions must:*

1. Present a physician’s statement excluding them from this requirement and
2. Attend the theory component of the CPR course.

Proof of exemption must be sent directly to the Nursing Dept. office, Room B-301, from the physician; attendance at the course must be validated.

**Deadline for all Requirements to be turned in: July 29, 2016**
Dear Level One Nursing Student:

Welcome to the Nursing Program at Bergen Community College. We have a proud 40+ year history of educating nurses to provide health care to area residents and beyond. The faculty and nursing administration rigorously and regularly reviews student and program outcomes always seeking new ways to improve the teaching/learning process. As a result of our studies, we are so pleased to introduce a program to further aid nursing students to learn the theory and clinical application of theory to nursing practice.

This program is an extension of our long affiliation with ELSEVIER/EVOLVE REACH testing and remediation. You may recognize the name because the entrance examination you took to qualify for the Nursing Program is an EVOLVE product. The program, utilized by numerous nursing programs throughout the country, will include the following products:

- Practice Tests and Case Studies
- Patient Reviews
- Assessment examinations to be offered at the end of each course

This program will provide YOU with personalized electronic remediation content; it will help you address your weaknesses. Your performance will be assessed in accordance with the categories tested on the HESI exit examination AND the national licensing examination, (NCLEX-RN) that you will be required to take to become a registered nurse.

We wish you the very best and will share in your success as you achieve your goal of becoming a registered nurse.

Dawn Kozlowski PhD, RN, CNE
Associate Dean of Nursing
There are many scholarships available for students enrolled in the Nursing Program at Bergen Community College. We encourage all students to take advantage of the financial assistance offered by the scholarships available at BCC.

Nursing student scholarships and the application can be viewed on the Bergen Community College web page via the following link:

http://www.bergen.edu/scholarships
Your nursing skills kit can be purchased in the campus Bookstore after June 6, 2016. Please make sure you purchase the kit and bring it with you for the second day of Orientation, June 16th, 2016.

Cost: $125.00
TEXTBOOKS FOR FALL 2015 AND SPRING 2016

LEVEL I
NUR 181 - Assessment

Or
Pagana: Mosby’s Diagnostic & Lab Test Reference, 12e, ISBN: 9780323225762

NUR 182 - Pharmacology / Math


NUR 183 – Concepts

or

or

Optional


Nursing Care Plan Books - student choice


LEVEL II

NUR 281/282 – Adult Health Nursing


LEVEL III

NUR 284 – Maternity and Pediatrics


NUR 285 – Psychiatric Nursing


LEVEL IV

NUR 290 / 291 Professional Role Management


BCC Library Databases Stat Ref: Online e books that you can access from any computer
- Davis's Comprehensive Handbook of Laboratory & Diagnostic Tests with Nursing Implications - 6th Ed. (2015)
- Davis's NCLEX-RN® Success - 3rd Ed. (2012)
- EKG Plain and Simple - 3rd Ed. (2012)
- Handbook of Fluid, Electrolyte, and Acid-Base Imbalances - 3rd Ed. (2010)
- Lippincott Manual of Nursing Practice - 10th Ed. (2014)
- Lippincott Nursing Procedures - 7th Ed. (2016)
- Lippincott's Video Series: Nursing Procedures (2009)
- Medical-Surgical Nursing Care - 4th Ed. (2016)
ORDER FORM - 2014

BERGEN COMMUNITY NURSING PROGRAM

Mr.  Mrs.
FULL NAME:  Ms.  Miss: __________________________ PHONE #: __________________

ADDRESS: _____________________________________________

CITY: __________________ STATE: __________ ZIP: __________ APT# __________________

PANTSUIT w/emblem sz ______ (   ) @ $54.00 ea. $ __________

NAME PIN sz ______ (   ) @ $  7.00 ea. $ __________

BANDAGE SCISSORS ______ (   ) @ $  5.00 ea. $ __________

WARM-UP JACKET w/emblem sz ______ (   ) @ $23.00 ea. $ __________

MENS TUNIC w/emblem sz ______ (   ) @ $25.00 ea. $ __________

MENS SLAX sz ______ (   ) @ $21.00 ea. $ __________

MENS WARMUP JACKET sz_______ (    ) @$26.00 ea. $ __________

* MINIMUM 2 GARMENTS IN ANY COMBINATION *

WARM-UP JACKET OPTIONAL

OTHER ITEMS AVAILABLE

SHOES style ______ sz ______ (   ) @ $ __________ ea. $ __________

STETHOSCOPE KIT color ______ (   ) @ $30.00 ea. $ __________

WATCHES (   ) @ $ __________ ea. $ __________

Shipping Charge $ 9.50

CASH * MONEY ORDER * CREDIT CARD

TOTAL $ __________

* PAYMENT AT TIME OF FITTING *

AMOUNT PAID $ __________

BALANCE $ __________

FITTING HOURS: Monday thru Saturday 10:00a.m. to 5:00p.m. NO APPOINTMENT NEEDED

PANTSUIT: tunic size ___________ alter tunic _________________

slax size _______________ alter slax _______________________
I hereby certify that I have read each page of the Nursing Student Handbook, that I am fully familiar with the contents of the document, and that I understand and have agreed to the terms and provisions. Any questions that I had about the nursing program and its handbook have been fully explained to my satisfaction.

NAME: ________________________________

please print

SIGNATURE: ______________________________

DATE: ______________________________

INFORMED CONSENT

I understand that the nursing program will include academic, laboratory, and clinical experiences and will include direct care or exposure to clients with a variety of illnesses and diseases, and will include the handling of and/or contact with human bodily fluids and tissues. I, therefore, understand that I may or will be exposed to disease causing bacteria and microorganisms.

In consideration of being permitted to participate in the Bergen Community College Nursing Program, I, the undersigned, in full recognition and appreciation of the dangers and hazards inherent in the health care field and in particular medical facilities, assume all of the risks and responsibilities surrounding my participation in the nursing program or my independent activities undertaken as an adjunct thereto and further I do for myself, my heirs, and personal representatives hereby agree to defend, hold harmless, indemnify and release and forever discharge Bergen Community College and all of its officers, agents, and employees from and against all claims, demands and actions, or causes of action on account of damage to personal property, or personal injury, disease, death, which may result to me from my participation in this program and my exposure to the risks inherent in this program.

NAME: __________________________________

Please print

SIGNATURE: ______________________________

DATE: ______________________________

Deadline for all Requirements to be turned in: July 29, 2016
NURSING STUDENT COMPLIANCE INFORMATION CHECKLIST

Health Services compliance information

☐ Nursing & Health Professions Immunization Requirement Form

☐ Health Services Medical Record

☐ Hepatitis B Vaccine Acceptance/Declination Form

☐ Nursing/Health Professions Students – Tuberculosis (TB) Screening Requirement

☐ LabCorp urine drug screening

☐ Flu Vaccination Form

Nursing Department compliance information

☐ Malpractice Insurance

☐ CPR Certification

☐ Student Handbook Sign-Off Form

Day of Orientation (or before)

☐ Purchase Nursing Skills Kit from Bookstore

☐ Purchase Textbooks or Bundles from Bookstore

The above compliance information must be completed and returned by July 29, 2016. Health Services information (the first five), should be submitted to Health Services Department, room HS100.

Malpractice, CPR Certification, Student Handbook sign-off form, as well as Health Services blue clearance form should be submitted to Ms. Darlene Zales-Russamano, Nursing Department, room B301. There is a drop box outside of office B301 if the office is closed.