

**LANDER UNIVERSITY
DEPARTMENT OF NURSING
ANNUAL HEALTH, INSURANCE, AND EDUCATION REQUIREMENTS
VERIFICATION FORM**

NAME: _____ E-MAIL ADDRESS _____
ID# _____ PHONE # _____

Submit this form with documentation **ATTACHED** to the Department of Nursing Office no later than **July 10 for fall semester and December 1 for spring semester.** This form **WILL NOT BE ACCEPTED** unless **ALL** required documentation is attached. *Faxed copies will not be accepted. (Readable photocopies of original documents are accepted.) ALL documentation must cover the entire academic year. Please keep a copy of all documents for your records. (Department of Nursing copying charge is \$1.00 per page).

Failure to submit this completed form with correct documentation by the deadline will result in CANCELLATION of your CLINICAL NURSING COURSES.

| | | Check Boxes Below | Provide Dates Below |
|-----------|---|---|---|
| 1. | <p>HEALTH & ACCIDENT INSURANCE Proof of medical insurance covering you for the entire academic year (ending in May).</p> | <input type="checkbox"/> Attached is a copy of face sheet ONLY of policy OR <input type="checkbox"/> Attached is a copy of insurance card | Name of Insurance Company _____ Date of Coverage _____ |
| 2. | <p>PROFESSIONAL LIABILITY INSURANCE Students are required to have professional liability insurance coverage annually in amounts not less than \$2,000,000 per occurrence; \$4,000,000 in aggregate effective throughout the academic year..</p> | <input type="checkbox"/> Attached is a copy of the face sheet ONLY of my policy showing the coverage dates. OR <input type="checkbox"/> Attached is a copy of my canceled check and front page of my application showing the coverage dates | Date of Coverage _____ |
| 3. | <p>CPR CERTIFICATION All students must show evidence of certification in CPR throughout the academic year. The American Heart Association's <u>HEALTHCARE PROVIDER BLS Course C* or Red Cross' PROFESSIONAL RESCUER*</u> courses are the ONLY courses ACCEPTED. (*Adult, child, infant CPR, management of obstructed airway and use of portable defibrillator)</p> <p>American Heart Association – renew every 2 years . alternate years review video OR Red Cross renew annually.</p> | Attached is a copy of CPR Certification Card CHECK (1) below: <input type="checkbox"/> American Heart Assoc. Healthcare Provider BLS Course C card OR <input type="checkbox"/> Red Cross Professional Rescuer card OR <input type="checkbox"/> Attached copy of letter from Instructor validating successful completion (NOTE: Bring a copy of your CPR card when received to the Department of Nursing office.) | Date of Certification _____ Date of Expiration _____ |

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|----|---|---|---|
| 4. | PPD (Tuberculin Test) An Annual PPD is required showing date and results of PPD in mm of induration and name of agency where it was completed. | <input type="checkbox"/> Attached is a copy of PPD with date placed and read | |
| 5. | Tetanus Proof of a tetanus booster given within the last ten (10) years. | <input type="checkbox"/> Attached is a copy of my record showing tetanus booster given within last ten (10) years | Date of Vaccine _____ |
| 6. | Hepatitis B Vaccination Students are required to have a series of three (3) Hepatitis B vaccinations which takes approximately 6 months to complete. Please fill in dates for all three (3) doses or titer even if you submitted an Initial Requirement form last year. (All doses may not have been reported.) Any student who is unable or unwilling to take the vaccine must sign a “waiver of declination”. | <input type="checkbox"/> Attached is a copy of health record showing dates of the completed series of immunization OR <input type="checkbox"/> Attached is a copy of Waiver of Declination | Date Hep B #1 _____ Date Hep B #2 _____ Date Hep B #3 _____ OR Date of titer : _____ OR Waiver of declination _____ (Form available in the Department of Nursing office) |
| 7. | Updated Health Examination Form | <input type="checkbox"/> Attached is copy of my completed and signed Updated Health Examination form | Date of Last Physical _____ |
| 8. | Criminal Background Check and Drug Screening Our clinical agencies require a criminal records check be conducted of all direct patient caregivers (including nursing students) in nursing homes, day care facilities for adults, home health agencies, and community residential care facilities. Some clinical agencies also require drug screening of all nursing students. Therefore, these are required of all nursing students annually. Instructions for completing the Criminal Background Check and Drug Screening can be found at www.landerbackgroundcheck.com . | <input type="checkbox"/> Attached are copies of <ol style="list-style-type: none"> 1. Completed and signed Lander Disclosure and Release Form 2. Lander University Background Check Order Confirmation and Receipt form 3. Forensic Drug Testing Custody and Control Form | ____ Lander Disclosure and Release Form ____ Lander University Background Check and Order Confirmation and Receipt form ____ Forensic Drug Testing Custody and Control Form |

I certify to the best of my knowledge that the above information is **true** and **complete** with **all documentation attached**. I authorize the Department of Nursing to release this information to the agencies where I have clinical laboratories.

DATE: _____

STUDENT SIGNATURE _____

You must provide the information below and return the form to Sue Bishop by July 10

FAILURE TO SUBMIT THIS COMPLETED FORM BY THE DEADLINE WILL RESULT IN LOSS OF YOUR SEAT IN THE NURSING MAJOR. No faxed copies.

NAME: _____ ACADEMIC YEAR 20 - 20
 L #: _____ DATE OF BIRTH: ___/___/___ LOCAL PHONE: _____
 ADDRESS: (HOME) _____
 (LOCAL) _____

| | | | |
|---|--|---|-----------------------|
| Indicate if you have ever been diagnosed or treated for any of the following. Provide additional information as indicated. (Key: Y= yes; N= no) | | | |
| <u>CIRCLE ALL THAT APPLY</u> | | | |
| Asthma or other respiratory problems | Diabetes | Low blood sugar | |
| Cardiac problems | High blood pressure | Kidney problems | |
| Bladder problems | Fainting/dizziness/loss of consciousness | Seizures (if yes, date of last seizure. Date: _____) | |
| Problems with vision (provide information on back of form) Do you wear glasses? Y N Contact lenses? Y N | Problems with hearing (provide information on back of form) Do you use a hearing device? Y N | Musculoskeletal problems (provide information on back of form) Does this problem limit mobility or lifting? Y N | |
| Other neurological/sensory problems (gait, smell, touch, etc) | Blood disorders (sickle cell anemia, hemophilia, etc) | Other medical or psychiatric conditions (provide information on back of form) | |
| Are you under medical care for the conditions circled above? Yes No | | | |
| Have you had any significant health changes in the last 12 months? Yes No If yes, explain (provide additional information on back of form) | | | |
| Describe your general health (circle): Excellent Good Fair Poor | | | |
| List name and purpose of any medications you are taking, including OTC. (provide additional information on back of form) | | | |
| List drug, food, or other allergies and any medical attention that is <i>immediately</i> required: Latex allergy? Y N | | | |
| Date Hepatitis #1: | Hepatitis #2: | Hepatitis #3: | Date of last tetanus: |
| Name & phone number of physician or nurse practitioner | | | |

EMERGENCY CONTACT INFORMATION: _____

In case of emergency, I give Lander Department of Nursing permission to obtain medical assistance and to notify my emergency contact person(s). Yes _____ No _____ (initial)

I understand that my medical information may be released to clinical agencies as required by agency contracts. Yes _____ No _____ (initial)

By my signature below, I verify that the information provided on this form is a true and accurate report of my health status.

SIGNATURE: _____ **DATE:** _____ (Date rec'd)

I AUTHORIZE THE DEPARTMENT OF NURSING TO RELEASE THIS INFORMATION TO THE AGENCIES WHERE I HAVE CLINICAL LABORATORIES.

 (Signature of Student)

 (Date)

INSTRUCTIONS FOR COMPLETING INITIAL/ANNUAL HEALTH, INSURANCE, AND EDUCATION REQUIREMENT FORM

1. HEALTH & ACCIDENT INSURANCE

Health and Accident Insurance is required of all nursing students. You must attach a copy of the face sheet (only) of the policy OR a copy of your insurance card.

2. PROFESSIONAL LIABILITY INSURANCE

All nursing students are required to have Professional Liability Insurance coverage in the amounts not less than \$2,000,000 per occurrence; \$4,000,000 aggregate effective throughout the academic year. **Attach** a copy of the face sheet (only) of the policy or a copy of the cancelled check and face sheet of the application. (The Professional Liability website is found on the Department website (www.lander.edu/nursing)).

3. CPR CERTIFICATION

All nursing students must show evidence of certification in CPR throughout the academic year. The American Heart Association BLS Course C or Red Cross Professional Rescuer courses are the **ONLY** courses accepted. This includes adult, child, infant CPR, management of obstructed airway and use of portable defibrillator. **Attach** a copy of your AHA BLS Course C or Red Cross Professional Rescuer CPR card.

4. PPD (Tuberculin Test)

Annual PPD is required to cover the academic year showing date and results of PPD in mm of induration. **Attach** copy of documentation OR copy of annual chest x-ray report if PPD was positive in the past.

5. TETANUS

Attach a copy of record showing proof of a tetanus booster given within the last 10 years.

6. HEPATITIS B VACCINATION

A series of three (3) Hepatitis B vaccinations are required. Please fill in dates for all three (3) doses or titer even if you submitted an Initial Requirement form last year. (All doses may not have been reported.)

Any student who is unable or unwilling to take the vaccine must sign a "waiver of declination".

7. HEALTH UPDATE FORM

The Annual Health Form must be completed in its entirety by 2nd semester sophomore, all junior and all senior students. All questions must be answered and dates completed (including Hepatitis and Tetanus dates, name and number of physician or nurse practitioner) or the form **will be returned** to the student. Include any significant changes in health status over the last 12 months.

8. CRIMINAL BACKGROUND CHECK AND DRUG SCREENING

Instructions for completing the Lander Department of Nursing Criminal Background Check and Drug Screening can be found at www.landerbackgroundcheck.com. After completing the on-line registration you will receive in the US Mail an information packet that includes locations for the drug screening.

| | |
|---|---|
| South Carolina residents select Package 1: | <u>Comprehensive Background Check AND Ten Panel Drug Screen.</u> |
| Out of State residents select Package 2 and 3 | <u>Criminal Background Check AND FBI Fingerprint plus Ten Panel Drug Screen</u> |

If you have questions, contact American DataBank, Customer Service phone: 303-573-1130 or 1-800-200-0853.

Print a copy of the Disclosure and Release form that is found on the first page of the website www.landerbackgroundcheck.com, a copy of the Lander Background Check Order Confirmation and Receipt form showing the amount paid and a copy of the Forensic Drug Testing Custody and Control Form after drug screening is completed. **Attach** all to the Verification Form with other documentation.

Submit ALL Documentations by the Deadline - (July 10 for fall; December 1 for spring admission).