

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

NAME: \_\_\_\_\_ LANDER E-MAIL ADDRESS \_\_\_\_\_  
ID# \_\_\_\_\_ PHONE # \_\_\_\_\_

Submit this form with **ALL** 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 loss of your seat in the nursing major.

		Check Boxes Below	Provide Dates Below
<b>1.</b>	<p><b>HEALTH &amp; ACCIDENT INSURANCE</b> Proof of medical insurance covering you for the entire academic year (ending in May).</p>	<p><input type="checkbox"/> Attached is a copy of face sheet <i>ONLY</i> of policy OR <input type="checkbox"/> Attached is a copy of insurance card</p>	<p>Name of Insurance Company _____ Date of Coverage _____</p>
<b>2.</b>	<p><b>PROFESSIONAL LIABILITY INSURANCE</b> 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>	<p><input type="checkbox"/> Attached is a copy of the face sheet <i>ONLY</i> of my policy OR <input type="checkbox"/> Attached is a copy of my canceled check and the front page <i>ONLY</i> of my application showing coverage date</p>	<p>Date of Coverage _____</p>
<b>3.</b>	<p><b>CPR CERTIFICATION</b> All students must show evidence of certification in CPR throughout the academic year. The American Heart Association's <b>HEALTHCARE PROVIDER BLS Course C*</b> or Red Cross' <b>PROFESSIONAL RESCUER*</b> courses are the <b>ONLY</b> courses ACCEPTED. (*Adult, child, infant CPR, management of obstructed airway and use of portable defibrillator) American Heart Association - renew every 2 years . alternate years review video OR Red Cross renew annually.</p>	<p>Attached is a copy of my CPR Certification Card <b>CHECK (1) below:</b> <input type="checkbox"/> American Heart Assoc. Healthcare Provider BLS Course C OR <input type="checkbox"/> American Red Cross Professional Rescuer  OR <input type="checkbox"/> Attached is a copy of a letter from my CPR instructor validating successful completion of Healthcare Provider or Professional Rescuer course.</p>	<p>Date of Certification _____ Date of Expiration _____  NOTE: Bring a copy of your CPR card when received to the Department of Nursing office to place in your file.</p>

4.	<b>PPD (Tuberculin Test)</b> <b>An Annual PPD is required showing date and results of PPD in mm of induration and name of agency where it was completed.</b>	<input type="checkbox"/> <b>Attached</b> is a copy of record of annual PPD showing date placed and date read.	
5.	<b>Tetanus</b> <b>Proof of a tetanus booster given within the last ten (10) years.</b>	<input type="checkbox"/> <b>Attached</b> is a copy of record showing tetanus booster given within the last ten (10) years.	Date of Vaccine _____
6.	<b>Measle-Mumps-Rubella (MMR)</b> <b>Proof of two (2) doses of Rubeola and Rubella</b>	<input type="checkbox"/> <b>Attached</b> is a copy of records showing (2) doses	Date of Vaccine 1 _____ Date of Vaccine 2 _____
7.	<b>Varicella (Chicken Pox) Immunization</b> <b>Proof of immunization or written documentation of the disease by a parent/guardian.</b>	<input type="checkbox"/> <b>Attached</b> is a copy of record showing varicella immunization OR <input type="checkbox"/> <b>Attached</b> is a written documentation from a parent/guardian	Date of Immunization _____  Date of Disease _____
8.	<b>Hepatitis B Vaccination</b> <b>Students are required to have a series of three Hepatitis B vaccinations which takes approximately 6 months to complete. Any student who is unable or unwilling to take the vaccine must sign a "waiver of declination".</b>	<input type="checkbox"/> <b>Attached</b> is a copy of record showing dates of the completed series of immunization OR <input type="checkbox"/> <b>Attached</b> 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)
9.	<b>Health Examination Form</b> <b>Health Examination must be completed by a Physician or Nurse Practitioner annually.</b>	<input type="checkbox"/> <b>Attached</b> is the completed and signed Health Examination form	Date of Physical _____
10.	<b>Criminal Background Check and Drug Screening</b> 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 <a href="http://www.landerbackgroundcheck.com">www.landerbackgroundcheck.com</a> .	<input type="checkbox"/> <b>Attached</b> are copies of <ol style="list-style-type: none"> <li>1. Completed and signed Lander Disclosure and Release Form</li> <li>2. Lander University Background Check Order Confirmation and Receipt form</li> <li>3. Forensic Drug Testing Custody and Control Form</li> </ol>	____ 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 \_\_\_\_\_

**HEALTH EXAMINATION - (To be completed by physician or nurse practitioner.)**Health Examination of \_\_\_\_\_  
(First Name) (Last Name)**Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_**Vision:** Uncorrected RE/20 \_\_\_\_\_ LE/20 \_\_\_\_\_

Corrected RE/20 \_\_\_\_\_ LE/20 \_\_\_\_\_

**Hearing:** (Whisper test 2 feet) R yes \_\_\_\_\_ no \_\_\_\_\_ L yes \_\_\_\_\_ no \_\_\_\_\_

Review of Systems: Note abnormalities (attach another sheet as necessary)

**GENERAL HEALTH:** \_\_\_\_\_ Excellent \_\_\_\_\_ Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor**VITAL SIGNS:** T \_\_\_\_\_ B/P \_\_\_\_\_ Heart rate \_\_\_\_\_ Respiratory rate: \_\_\_\_\_

Significant past medical history

**PPD** Placed? \_\_\_\_\_ no \_\_\_\_\_ yes \_\_\_\_\_ Date Placed \_\_\_\_\_

Date read \_\_\_\_\_

Results \_\_\_\_\_ mm induration

If PPD positive, follow up \_\_\_\_\_

Significant changes in health status over last 12 months? \_\_\_\_\_ no \_\_\_\_\_ yes  
(explain) \_\_\_\_\_

Current health status: Medications: \_\_\_\_\_

Alcohol/Drug use: \_\_\_\_\_ Smokes: \_\_\_\_\_ Amt: \_\_\_\_\_

Other: \_\_\_\_\_

**Physical Exam:** (Check if examined)

\_\_\_\_\_ HEENT \_\_\_\_\_ CV \_\_\_\_\_ RESP. \_\_\_\_\_ GI \_\_\_\_\_ GU

\_\_\_\_\_ MS \_\_\_\_\_ NEURO \_\_\_\_\_ SKIN \_\_\_\_\_ MENTAL STATUS

ABNORMAL FINDINGS: \_\_\_\_\_ NONE. \_\_\_\_\_ YES (explain) \_\_\_\_\_

Nursing students are required to perform physical assessment and nursing care strategies that utilize sensory and psychomotor abilities. This requires physical agility and strength sufficient to move from room to room, lift and position patients, maneuver in small places, and perform nursing actions; gross and fine motor abilities sufficient to provide safe and effective nursing care; and auditory, visual, and tactile acuity sufficient to assess health status and perform nursing actions.

Based upon my examination and interview of the above named individual there does not appear to be any health condition present that would prevent this individual from participating as a nursing student at Lander University under the current ADA Guidelines stated above.

**Physician/Nurse Practitioner Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

PRINT SIGNATURE \_\_\_\_\_

**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](http://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 yearly** 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. MEASLE-MUMPS-RUBELLA (MMR)

**Attach** a copy of proof of two (2) doses of Rubeola and Rubella (MMR) or titer results.

### 7. VARICELLA (CHICKEN POX)

**Attach** a copy of proof of immunization of varicella or titer results or attach a statement of the disease from parent or guardian.

### 8. HEPATITIS B VACCINATION

A series of three (3) Hepatitis B vaccinations are required. Attach a copy of documentation of dates of completed series or documentation that the series has been started or attach titer results. Any student that is unable or unwilling to take the vaccine must sign a "waiver of declination" which may be obtained from the Department of Nursing.

### 9. HEALTH EXAMINATION FORM

First (1<sup>st</sup>) semester sophomores and new students to Lander admitted to the nursing major must have a physician or nurse practitioner complete the Initial Health Examination form.

The Annual Health Form must be completed in its entirety by 2<sup>nd</sup> semester sophomores, juniors and seniors.

(All questions and dates MUST be completed or the form will be returned.)

### 10. 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](http://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:	Comprehensive Background Check AND Ten Panel Drug Screen.
Out of State residents select Package 2 and 2	Criminal Background Check AND FBI Fingerprint PLUS Ten Panel Drug Screen

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 (found on the first page of the website ([www.landerbackgroundcheck.com](http://www.landerbackgroundcheck.com)), a copy of the Lander Background Check Order Confirmation and Receipt form (showing the amount paid for the check and screening), and a copy of the Forensic Drug Testing Custody and Control Form received after screening is completed.

**Attach** all documents to the Verification Form with other documents.

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