INFORMATION SHEET

Please read carefully (9 pages) Documents and money must be submitted before clinicals.

	New students complete all steps. **Readmit students complete steps 1,2,4,5,7,8,9,10,11,12 only**	**DEADLINES** **NEW Students**	**DEADLINES** **(Readmission Students)**
Step 1	**Physical Form** (Cream Sheet) - – Make your appointment date as soon as possible. ***Dates are important*** – Check the boxes when completed! Be SURE your physician or Nurse Practitioner has documented in ***all*** the spaces. ☐ Complete Physical form on both sides (cream sheet) side 1 completed by student side 2 completed by Nurse practitioner or MD ☐ TB Skin Test with date and results ☐ Tetanus with date ☐ (2)MMR's with date (or rubella and rubeola and mumps titers results/date) ☐ First Hepatitis B with date or dates when all were completed ☐ Proof of History of Varicella or the Varicella Vaccine *****STUDENT MUST TURN IN ORIGINAL CREAM COLORED PHYSICAL FORM FROM THE HEALTH PROGRAMS OFFICE. NO COPIES OR UNOFFICIAL FORMS WILL BE ACCEPTED.**	**Student makes her/his appt.** **Physician must complete on physical form** **Submit Orientation August 7**	**Student makes her/his appt.** **Physician must complete on physical form** **Submit July 20 or 21**
Step 2	**Insurance Forms** Go to: **WWW.NSO.COM** (1-800-247-1500)– enter virtual customer service representative (VCSR) – Make your policy account by following the directions. Your price is $29 student nurse 1/6M coverage and policy should state registered nurse student. (This price may vary if student holds another professional licensure). Make coverage effective first day of class. Please have confirmation and verification faxed to Health Programs office –(FAX 423-585-6955) If you are licensed or credentialed in more than one healthcare profession such as CNA, LPN, EMT etc, and therefore need to apply for dual coverage, you must call 1-800-247-1500.)	**Proof of coverage and payment due Orientation August 7**	**Proof of coverage and payment due July 20 or 21**
Step 3	**Nurse Kit Order:** Complete order form. Fax or Mail order form and payment directly to Smitty's. ***You will need this the second week of class, so order by deadline!***	**August 7**	**N/A**
Step 4	**CPR** – Submit copy of front/back of CPR Card. Completion card ***must*** be ***American Heart Association, Health Care Provider.***	**August 7**	**July 20 or 21**
Step 5	**Hepatitis B Series Vaccination Verification** (White sheet) –This must be signed and dated in addition to the physical form.	**August 7**	**N/A**
Step 6	**Photos** - One (1) photo (candid shot from home is fine) with signature.	**August 7**	**N/A**
Step 7	**Consent Forms** - Please complete and/or sign: Consent Form, Student Conduct Form, HIPPA (Privacy agreement), Criminal Background form and Drug/Alcohol Abuse Policy (a portion of this info is in your handbook that you are required to read)	**August 7**	**N/A**
Step 8	**"Information Packet "** All the material must be hand-delivered to: Orientation	**August 7**	**N/A**
Step 9	**HESI** (Assessment Testing fee) Fee varies by semester and class: Pay only for semester enrolled. ***Make a copy of receipt and turn in with packet.*** **1160** Fee **- $21 (Fundamentals)** — **2610** Fee - **$40 (Med Surg)** **2620** Fee **- $79 (Advanced Med Surg)** — **2600** Fee - **$84 (OB, Peds, Psych)** HESI fees are paid through the WSCC Business Office. Acceptable means of payment are credit card, debit card, cashiers check, money orders or cash. Cashiers check/money orders are payable to Walters State Community College.	**Pay the WSCC Business Office no later than 1st day of class – Aug 29 (To be discussed at orientation)**	**Pay the WSCC Business Office no later than 1st day of class – Aug 29.**
Step 10	**TNF** (Tennessee Nurses Foundation) $5 Fee – TNF fees are paid through the WSCC Business Office. ***Make a copy of receipt and turn in with packet***. Acceptable means of payment are credit card, debit card, cashiers check, money orders or cash. Cashiers check/money orders are payable to Walters State Community College. If you are an LPN, this fee is waived.	**Pay the WSCC Business Office no later than 1st day of class – Aug 29.**	**Pay the WSCC Business Office no later than 1st day of class – Aug 29.**
Step 11	**Criminal Background Check – A criminal background check is required for participation in most clinical experiences. Students will be required to submit a clear background check. The cost will be approximately $100. Plan to have funds available to purchase this background check immediately following the orientation. More instruction and info will be provided at orientation.**	**Instructions at Orientation**	**Instructions at Orientation**
Step 12	**MAKE A COPY OF ALL OF YOUR FILES FOR FUTURE REFERENCE!** Professional development implies that **YOU** maintain your personal records of the above.	**Make copies for yourself**	**Make copies for yourself!**
Step 13	**Medical Information Form – This form must be completed and on top of information packet when submitted.**	**Orientation August 7**	**July 20 or 21**

Questions? Please call 423-585-6982

Criminal Background checks may be a requirement for training at some affiliated clinical sites. Based on the results of these checks, an affiliated clinical site may determine to not allow your presence at a facility. Additionally, a criminal background may preclude licensure or employment. If you are assigned to a clinical affiliate requiring a criminal background check, you will be required to provide the requested information. Acceptance of you as a student in the clinical facility will be at the clinical affiliate's discretion. As a student, you will be responsible for the cost of any required background checks. If a clinical affiliate denies your presence in the facility, you will not be able to complete the clinical/practicum and you will be withdrawn from the program. The specifications for the background check are at the discretion of the clinical affiliate. Should the affiliate not require a specific vendor for the check, the program director will provide a list of available vendors to purchase the required criminal background check. The cost of the criminal background check will average $50.00-$100.00. The exact amount may vary based on the affiliate specifications and individual student differences. As a student you will not be allowed access to a clinical facility for any student experience until the clinical facility has authorized your presence.

To assist us in allowing others into the program, please notify us if your plans change. Call 423-585-6870

Medical Information Data

Data must be completed by student in order to continue enrollment in nursing.

Insurance Expiration ____

CPR Expiration ____

Insurance Coverage ____
1/3 M or 1/6 M

Physical Date ____

Policy Coverage must be for: RN Student Nurse ____

TB DATE ____ **MMR1 DATE** ____ **MMR2 DATE** ____

Titers DATE ____
(if applicable)

HB1 ____ **HB2** ____ **HB3** ____

Titers DATE ____
(if applicable)

VARICELLA ____
(Chicken Pox History or Vaccine)

FORMS

CONSENTS ____
Y/N

DRUG/ALC ____
Y/N

CONDUCT ____
Y/N

PHOTO ____
Y/N

HESI RECEIPT ____
Y/N

TNF RECEIPT ____
Y/N

______________________ DATE ______________________ Signature

The above information is correct and verifies documentation submitted.

WALTERS STATE COMMUNITY COLLEGE
DIVISION OF HEALTH PROGRAMS

HEPATITIS B SERIES VACCINATION VERIFICATION

Due to your exposure to blood or other potentially infectious materials, you may be at risk of acquiring hepatitis B Virus (HBV) infection. It is strongly recommended that you be vaccinated with Hepatitis B vaccine, prior to your clinical experience. Without the Hepatitis B vaccination you will continue to be at risk of acquiring Hepatitis B. Prior to your clinical experience, you will be taught in campus labs the guidelines and procedures for standard precautions.

Choose one of the following and sign to indicate your choice of action to this statement

I. I have read this statement and understand it. I plan to take the Hepatitis B vaccine on:

____
DATE

______________________________ ______________________________
SIGNATURE DATE

II. I have already had the Hepatitis B vaccine.

____
DATE OF FIRST INJECTION

____
DATE OF SECOND INJECTION

____
DATE OF THIRD INJECTION

____
SIGNATURE

III. I have read this statement and understand it. I do not plan to take the Hepatitis B vaccine.

____
SIGNATURE

____
DATE

WALTERS STATE COMMUNITY COLLEGE
DEPARTMENT OF NURSING
CONSENT FORM

I,_________________________ am enrolled in the Nursing program at Walters State Community College (WSCC). I acknowledge receipt and understanding of the Walters State Community College Nursing Program Student Handbook. My signature indicates that I have read and understood this consent and release, and I have signed it voluntarily in consideration of enrollment in the Nursing Program at Walters State Community college.

Place initials beside each section

I._____ I have obtained a copy of the WSCC Nursing Program Student Handbook and catalog and agree to abide by the policies within.

II._____ I hereby give permission for the WSCC Department of Nursing to release information regarding my malpractice insurance policy and Basic Life Support course Completion to the clinical agency where I am assigned.

III._____ I hereby give permission for a copy of my current Health History and Physical or information from that document to be submitted to clinical facilities or their designees where I am assigned. I understand that this information will be released only by request of the clinical facility(s).

IV._____ I hereby give my permission for photocopying of my written work. I understand that this material is to be utilized by the faculty for curriculum evaluation and development. I understand that my name will not appear on the copy.

V._____ I hereby give permission to the WSCC Department of Nursing to release my name, address and phone number for professional and recruiting purposes (i.e., employment). I authorize educational instructors to answer all questions asked concerning my ability, character, reputation and previous employment/educational record. I understand and acknowledge that my personal information (i.e., name, address, and phone number) may be confidential information in my educational record as protected by the Family Educational Rights and Privacy Act if I have requested that WSCC not designate that data as directory information; however, I consent to its release by the WSCC Department of Nursing for the limited purpose of employer recruiting. I release all such persons from any liability or damages on account of having furnished such information.

VI.____ I have read the Standard Precautions Procedure. I agree by my signature to abide by the contents within.

VII.____ I understand that WSCC strongly recommends every student to carry health insurance and that I am responsible for all costs incurred related to health problems or accidents should these occur while functioning in the role of a student.

VIII.____ I hereby give my permission for the Walters State Community College Nursing Program to use (and/or reproduce) my image (photograph, video, etc.) for educational purposes only. The images that I allow relate directly to activities of the Nursing Program and will be used only to enhance my learning, the learning of other students, and assessment by faculty, curriculum evaluation and development, and publicity. These images will be retained by Walters State Community College.

I hereby acknowledge by my signature below that I accept and understand the policies with which I must comply throughout my enrollment in the WSCC Nursing Program. I further acknowledge that I will comply with all policies outlined in this document and policies that are made known to me in other WSCC or clinical affiliate site documentation, including handbooks and syllabi. I acknowledge that I affirmatively agree to each of the provisions of this document as indicated by my initials beside each section of this Consent Form.

_________________________________ _________________________
Student's Signature Date

____
Student's Name (Print)

AGREEMENT FOR STUDENTS IN THE HEALTH PROGRAMS AT WSCC REGARDING STUDENT CONDUCT

The WSCC Health Program student agrees to conduct himself or herself in a professional, honorable, and ethical manner.

I. Professional Behaviors
   A. Actively participates and accepts responsibility for learning
   B. Effectively communicates
   C. Demonstrates dependability
   D. Demonstrates appropriate adaptability
   E. Appropriately utilizes resources
   F. Maintains acceptable level of personal appearance

II. Honorable and Ethical Behaviors
   A. Demonstrates accountability for all actions
   B. Demonstrates respect in all situations
   C. Demonstrates ethical behavior in all situations

By accepting admission to the health programs as WSCC you are voluntarily agreeing to abide by the Student Conduct Agreement.

This in no way negates or limits policies and procedures in program specific material.

Signature of student _______________________________ Date _________

WALTERS STATE COMMUNITY COLLEGE
NURSING PROGRAM
Student Confidentiality/Non-Disclosure Acknowledgement

Student____

As a student in the Nursing Program, I understand that I will be working with medical records and confidential information for patients at various healthcare facilities.

I understand that healthcare facilities remind their employees and volunteers of their confidentiality obligations on a periodic basis to help ensure compliance, due to the significance of this issue.

The healthcare facility/facilities that I may be assigned to have a legal and ethical responsibility to safeguard the privacy of all patients and protect the confidentiality of their health information. In the course of my assignment at any healthcare facility that is an Affiliate of Walters State Community College, I may come into possession of confidential patient information.

Medical records are confidential, legal, personal documents. The contents of individual patient's medical records are to be kept strictly confidential. As a condition of my assignment, I hereby agree that, unless directed by my instructor, I will not at any time during or after my assignment with the Affiliate healthcare facility disclose any patient information to any person whatsoever or permit any person whatsoever to examine or make copies of any patient reports or other documents prepared by me, coming into my possession, or under my control, or use patient information, other that as necessary in the course of my assignment. When patient information must be discussed with other health care practitioners in the course of my work, I will use discretion to assure that such conversations cannot be overheard by others who are not involved in the patient's care.

Nursing students must also treat as confidential all information relating to the personal, financial, and business affairs of the healthcare facility and its employees.

I pledge not to discuss the contents of any patient's medical record or any confidential information which comes to my knowledge except when such discussion is relative to the learning experience. I further agree to abide by the Health Insurance Portability and Accountability Act (HIPAA) guidelines in effect at the individual healthcare facility to which I am assigned. I understand that a violation of confidentiality in any of the above-described areas may be grounds for dismissal from the Nursing Program. I also understand that I may be in violation of the regulations of the Health Insurance Portability and Accountability Act of 1996 as effective April 14, 2003.

____

Student's signature **Date**

WALTERS STATE COMMUNITY COLLEGE
AUTHORIZATION FOR RELEASE OF STUDENT INFORMATION AND ACKNOWLEDGEMENT

I, __________________________ hereby authorize Walters State Community College, ("Institution") including all employees, agents, and other persons professionally affiliated with Institution having information related to the results of my background check and credential check(s) as these terms are generically used by background check agencies, hospitals, clinics and similar medical treatment facilities, to disclose the same to such facilities and the appropriate institutional administrators and faculty providing clinical instruction at such facilities, waiving all legal rights to confidentiality and privacy.

I expressly authorize disclosure of this information, and expressly release Institution, its agents, employees, and representatives from any and all liability in connection with any statement made, documents produced, or information disclosed concerning the same.

I understand that a hospital, clinic, or similar medical treatment facility may exclude me from clinical placement on the basis of a background check. I further understand that if I am excluded from clinical placement, I will not be able to meet course requirements and/or the requirements for graduation. I release Institution and its agents and employees from any and all liability in connection with any exclusion that results from information contained in a background check.

Any hospital, clinic or similar medical treatment facility to which I am assigned may be required by the Joint Commission on Accreditation of Healthcare Organizations' policy to conduct an annual compliance audit of five percent (5%) or a minimum of thirty (30) background investigation files. I agree that, upon request from a hospital, clinic or similar medial treatment facility to which I am assigned, I will provide the results of my background check to be used for audit purposes only.

____
Student Signature

____
Print Name

____
Date

Consent to Drug/Alcohol Testing
Statement of Acknowledgment and Understanding
Release of Liability

I, ___________________________ am enrolled in the Allied Health and/or Nursing program at Walters State Community College. I acknowledge receipt and understanding of the institutional policy with regard to drug and alcohol testing, and the potential disciplinary sanctions which may be imposed for violation of such policy as stated in the Walters State Community College Student Handbook.

I understand the purpose of this policy is to provide a safe working and learning environment for patients, students, clinical and institutional staff; and property. Accordingly, I understand that prior to participation in the clinical experience, I may be required to undergo drug/alcohol testing of my blood or urine. I further understand that I am also subject to testing based on reasonable suspicion that I am using or am under the influence of drugs or alcohol.

I acknowledge and understand the intention to test for drugs and/or alcohol and agree to be bound by this policy. I hereby consent to such testing and understand that refusal to submit to testing or a positive result of the testing may affect my ability to participate in a clinical experience, and may also result in disciplinary action up to and including dismissal from Walters State Community College.

If I am a licensed health profession, I understand that the state licensing agency will be contacted if I refuse to submit to testing or if my test results is positive. Full reinstatement of my license would be required for unrestricted return to the Walters State Community College Allied Health and/or Nursing Program.

My signature below indicates that:
I consent to drug/alcohol testing as required by clinical agencies or as directed by the Office of Student Affairs.
I authorize the release of all information and records, including test results relating to the screening or testing of my blood/urine specimen, to the Office of Student Affairs, the Director of the Allied Health and/or Nursing Program, and others deemed to have a need to know.
I understand that I am subject to the terms of the general regulation on student conduct and disciplinary sanctions of Walters State Community College, and the Drug-Free Campus/Workplace Policy of Walters State Community College, as well as, federal, state and local laws regarding drugs and alcohol.
I hereby release and agree to hold harmless Walters State Community College and the Tennessee Board of Regents, their officers, employees and agents from any and all action, claim, demand, damages, or costs arising from such test(s), in connection with, but not limited to, the testing procedure, analysis, the accuracy of the analysis, and the disclosure of the results.

My signature indicated that I have read and understand this consent and release, and that I have signed it voluntarily in consideration of enrollment in the Allied Health and/or Nursing Program at Walters State Community College.

_________________________________ ________________

Student's Signature **Date**

ORDER FORM FOR NURSE KIT

Walters State Community College

Requirement for Nursing 1150 (skills lab)

Fall 2009

The Nurse Kit contains supplies to be utilized in the skills lab during the first and subsequent semesters of the nursing program. Please place your order directly to the address below **(not to WSCC.) Once students have placed all orders, Smitty's Surgical Specialties will ship the kits directly to Walters State Community College where the instructor will distribute the kits the first week of the 1150 class (skills lab.)** Please place your order by August 7, 2009

Note: order is nonrefundable. If you are unable to place your order for any reason, contact secretary of WSCC at 423-585-6870 before August 7, 2009.

How to order:

1. Complete the following information: **PRINT legibly**

   Name ______________________ Daytime phone: (   ) ______________

   Street Address ____

   City ___________________________State _____ Zip code ___________

   Email address for confirmation of receipt of order___________________

2. **Cost: $62.50** latex free
   Check method of payment:
   Personal Check _____ Money Order_____ Cashier check _____(enclosed)
   Credit card Name ______________________Number ________________
   and 3 digit security code on back ________ Exp. date _______________

3. **FAX or MAIL this completed order form and payment source to:**

   Smitty's Surgical Supplies
   2010 Middlebrook Pike
   Knoxville, TN. 37921
   Phone: 1-800-591-9997
   FAX: (865) 525-7849