



School  
of Nursing

# PROGRAM AND HEALTH REQUIREMENTS FOR BSN STUDENTS

## PROGRAM AND HEALTH REQUIREMENTS FOR STUDENTS

This packet contains information and forms which must be completed. Please adhere to the appropriate deadlines for document submission and upload relevant forms to your Exxat profile.

### Prelicensure Student Handbook:

1. Go to the School of Nursing homepage at:  
<https://nursing.csuohio.edu/information/information-for-current-students>
2. Read the *Undergraduate Prelicensure Student Handbook* completely
3. The following documents from the *Undergraduate Prelicensure Student Handbook* can be accessed & uploaded through your Exxat profile:
  - Memorandum of Understanding
  - Media Release & Copyright Permission
  - Informed Consent, Assumption of Risk, and Release of Records
  - Safety & Technical Standards Acknowledgment
  - Drug Screen Acknowledgment

### Program and Health Data Documentation Required:

CSU Health & Wellness Services provides medical services and immunizations for students. For additional information, please see the next page.

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Health History and Examination  | <input type="checkbox"/> Hepatitis B Vaccine Series | <input type="checkbox"/> Measles Mumps Rubella (MMR) Titer |
| <input type="checkbox"/> Tdap  | <input type="checkbox"/> Hepatitis B Titer          | <input type="checkbox"/> Varicella Titer                   |
| <input type="checkbox"/> Tuberculin (TB/Mantoux) Skin Test <i>or</i> QuantiFERON <i>or</i> T-Spot <i>or</i> Chest X-Ray Verification | <input type="checkbox"/> COVID-19 Vaccination       | <input type="checkbox"/> Seasonal Influenza Vaccination    |

***Before submitting the documents listed above – make a copy for your own records***

### Additional Information Required:

- |  |  |
|--|--|
| <input type="checkbox"/> Health Insurance Verification | <input type="checkbox"/> Fingerprinting and Background Check Information |
| <input type="checkbox"/> CPR Certification             | <input type="checkbox"/> Uniform – Dress Code Requirements               |



School of  
Nursing  
COLLEGE OF HEALTH

The management of your program and health data required for your clinical experiences will be done using Exxat APPROVE. There is an annual fee of \$36 (to be paid by each student). Exxat is built to collect and share HIPAA and FERPA protected information. Documentation that is uploaded to your Exxat profile will be verified by the Exxat team of medical professionals. Each student is responsible for maintaining compliance with all program requirements. Your profile must remain current for the duration of the program. Both scheduled and random audits will be performed to ensure compliance. You must adhere to all deadlines related to the submission of verifiable documentation to be eligible for placement into your nursing classes.

## Welcome CSU Nursing Students!

*We are here to help you with your medical admission requirements*

# Health & Wellness Services

College of Health  
2112 Euclid Ave, Room 205  
Monday – Friday, 8am – 5pm  
(across from the Student Center)



CSU MetroHealth Clinic:  
Located in the College of Health, 2112 Euclid Avenue, Room 205

CSU Clinic is a high-quality medical facility committed to serving the medical needs of the CSU community. Staffed by certified nurse practitioners and doctors, it offers a wide variety of services including primary and same day care, health counseling, limited in-house pharmacy and lab services, shots, immunizations, and more.

Health related questions: [CSUHealthCenter@metrohealth.org](mailto:CSUHealthCenter@metrohealth.org)

Insurance related questions: [StudentBelonging@csuohio.edu](mailto:StudentBelonging@csuohio.edu)

**For MetroHealth Billing Questions:** Please reach out to **216-957-3250** to discuss billing and Patient Financial Services. All of MH charity care policies and sliding scale fees are extended to the CSU Health Center

**Students and Employees can schedule an appointment at the on campus clinic by calling 440-592-1900.**

*Fees for clinic visit, laboratory testing services, immunizations, medications and vaccines are payable at the time service is rendered unless other arrangements have been made. CSU IDs are required for IOUs. Health & Wellness Services accepts most insurances and self-payments.*

## Health Examination Medical Form

**A physical examination is required for all students upon admission to the Nursing Program.** The student may have a physical examination performed by his/her private provider/nurse practitioner or at CSU Health & Wellness Services Department. Complete the personal information and health history sections below and give to your provider/nurse practitioner to complete the physical examination portion. **This information will be treated confidentially.**

Last	First	M.I.	CSU ID Number
Street Address:			
	City	State	Zip
( )	( )	/ /	
Home Phone with Area Code	Cell Phone with Area Code	Date of Birth	

### HEALTH HISTORY

**COMPLETE BEFORE VISIT WITH PROVIDER/NURSE PRACTITIONER**

**Have you had or do you now have any of the following: (please check all YES answers)?**

<input type="checkbox"/> Allergies	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Migraine Headaches	<input type="checkbox"/> Shortness of Breath on Exertion
<input type="checkbox"/> Anemia	<input type="checkbox"/> Heart Trouble	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Sickle Cell Disease/Trait
<input type="checkbox"/> Asthma	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Psychological/Psychiatric Problems	<input type="checkbox"/> Strep Throat
<input type="checkbox"/> Cancer	<input type="checkbox"/> Joint Pains	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Stroke
<input type="checkbox"/> Cold Sores (frequent)	<input type="checkbox"/> Kidney Pain	<input type="checkbox"/> Scarlet Fever	
<input type="checkbox"/> Cough (persistent)	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Seizures	

Do you have any physical impairment that limits your activity?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<i>If yes, please explain:</i>
Do you have any other medical issues not listed?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<i>If yes, please explain:</i>
Are you presently taking any kind of medication(s)?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<i>If yes, please name drug(s) and how often taken:</i>
Do you have any allergies (food, medicine, latex, environmental)?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<i>If yes, please list:</i>

**I hereby certify that I have read and understand all the above questions and have responded to them to the best of my knowledge. I also consent to the release of medical information to the Program and clinical site.**

\_\_\_\_\_  
Student's Signature

\_\_\_\_\_  
Date

Cleveland State University ▪ School of Nursing

Student Name: \_\_\_\_\_ CSU ID: \_\_\_\_\_ Date: \_\_\_\_\_

PHYSICAL EXAMINATION	*ABNORMAL	HEIGHT	WEIGHT	PULSE	B/P
General Appearance					
<b>PHYSICIAN'S NOTE OF PHYSICAL &amp; SUMMARY OF SIGNIFICANT FINDINGS</b> <i>*Abnormal findings must have documentation</i>					
	NORMAL	*ABNORMAL with note:			
Skin					
Eyes incl. Fundus					
Ears / Hearing					
Nose / Sinuses					
Mouth / Throat					
Neck incl. Thyroid					
Chest incl. Breasts					
Heart					
Vascular System					
Lymphatic System					
Abdomen incl. Inguinal					
Nervous System					
Extremities					
Spine, other Musculoskeletal					

**Provider/Nurse Practitioner Certification:** *I certify that the above student has completed a physical examination within the last six months; is able to perform duties within the requirements of the program; and is free from communicable disease(s).*

Provider/Nurse Practitioner Name & Credentials (Please Print) Office Address City, State Zip Code  
*This information must be legible and include professional credentials*

Provider/Nurse Signature Date

**Place Provider's Office Stamp in the Box on the Right for Validation.**  
 Once completed, upload all relevant forms to your Exxat profile.



**IMMUNIZATION STATUS**

Students must provide documentation of satisfactory immunization status for the following:

<b>Tetanus, Diphtheria, and Pertussis</b>	Every adult should get a Tdap vaccine once if they did not receive it as an adolescent to protect against pertussis (whooping cough), and then a Td (tetanus, diphtheria) or Tdap booster shot every 10 years.
<b>MEASLES MUMPS RUBELLA (MMR)</b>	Students must show proof of a positive titer. If titer is negative, student must be re-immunized and retested with blood titer results showing immunity recorded on the <b>Measles Mumps Rubella (MMR) Immunization</b> form. <i>Rubella</i> also known as German Measles; <i>Rubeola</i> also known as English Measles.
<b>VARICELLA</b>	Students are required to submit proof from a provider or health institution of having a positive titer. If titer is negative, student must be re-immunized and retested with blood titer results showing immunity recorded on the <b>Varicella (Chicken Pox) Immunization</b> form.
<b>Tuberculin (TB) (MANTOUX) TEST</b>	FIRST YEAR: 2-step PPD or QuantiFERON blood test or T-Spot blood test is required within 4 months of the start of your program (interval between the 2 steps should be at least 1-3 weeks). TB must be completed annually throughout the program. A provider will determine the appropriate follow-up for positive results. The results of the TB Mantoux Test or Chest X-Ray should be indicated on the <b>QuantiFERON or Tuberculin Mantoux Skin Test (or Chest X-Ray)</b> form. The TB (Mantoux) and/or Chest X-Ray can be administered by your private provider or at the County Tuberculosis Clinic located on the ground floor of the Bell Greve Building at Cleveland MetroHealth Medical Center. The telephone number is 216-778-8305. An appointment is required. The TB (Mantoux) is also available at CSU Health & Wellness Services.
<b>HEPATITIS B</b>	Clinical sites require all nursing students receive the Hepatitis B vaccine series and titer. This is to be administered as a series of two or three. Documentation of a positive titer is required to show immunity. If titer is negative, student must be re-immunized and retested with blood titer results showing immunity recorded on the <b>Hepatitis B Immunization</b> form. The vaccine is also available at CSU Health & Wellness Services.
<b>SEASONAL INFLUENZA (FLU) VACCINATION</b>	The Centers for Disease Control established the requirement that anyone working in any health care setting must receive a Flu Shot every year. Documentation must be recorded on the <b>Seasonal Influenza (Flu Shot) Vaccination</b> form and submitted by October 15 <sup>th</sup> ANNUALLY to be qualified to continue or begin clinical. <b>**In case of an allergic reaction to the flu vaccine, official documentation must be submitted from the provider annually, listing the diagnosis and the provider's contact information. Clinical or fieldwork assignments will be pending the availability of a facility/site that allows Flu vaccine exemptions for students.</b>
<b>COVID-19 VACCINATION</b>	All students are required to receive the COVID-19 vaccine. Acceptable forms of documentation: copy of COVID vaccination card or copy of immunization record from provider's office. Please note, exemptions can be requested through the Office for Institutional Equity (OIE) or the Office of Disability Services (ODS). Contact <a href="mailto:csuschoolofnursing@csuohio.edu">csuschoolofnursing@csuohio.edu</a> for more information. <b>Clinical or fieldwork assignments will be pending the availability of a facility/site that allows Covid-19 vaccine exemptions for students.</b>

## TETANUS-DIPHTHERIA AND PERTUSSIS (TDAP) BOOSTER IMMUNIZATION

Student Name: \_\_\_\_\_

CSU ID: \_\_\_\_\_

***Must be administered every ten (10) years***

Date Administered: \_\_\_\_\_

Lot #: \_\_\_\_\_

Batch Expiration Date: \_\_\_\_\_

Site of Injection:

Left  
Deltoid

Right  
Deltoid

Provider/Nurse Practitioner Name & Credentials (Please Print)

Office Address

City, State

Zip Code

*This information must be legible and include professional credentials*

Provider/Nurse Signature

Date

*\*Results from your electronic medical record information system (MyChart, etc.) may be substituted in lieu of this form. Once completed, upload relevant form(s) to your Exxat profile.*

**Place Provider's Office Stamp in the Box on the Right for Validation**

*Place Provider's Stamp in this Box  
for Validation\**

Cleveland State University ▪ School of Nursing  
**TUBERCULIN (TB/MANTOUX) SKIN TEST**  
(OR CHEST X-RAY WHEN NECESSARY)

Student Name: \_\_\_\_\_ CSU ID #: \_\_\_\_\_

**FIRST YEAR: 2-Step TUBERCULIN (MANTOUX) SKIN TEST  
or QUANTIFERON BLOOD TEST or T-Spot**

*2-step PPD or QuantiFERON blood test or T-spot blood test is required within 4 months of the start of your program  
(interval between the two steps should be at least 1-3 weeks)*

**OPTION 1 -- Enter results of 2-step TB test here:**

**STEP ONE: UPON ADMISSION** and annually

**STEP TWO: To be administered 1-3 weeks after Step One  
(first year of program only)**

Date administered: \_\_\_\_\_

Date administered: \_\_\_\_\_

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

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

Results:  Positive  Negative

Results:  Positive  Negative

**OPTION 2 -- Enter results of QuantiFERON/T-Spot here:**

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

Results:  Positive  Negative

**ANNUALLY: 1-Step TUBERCULIN (MANTOUX) SKIN TEST or QUANTIFERON/T-Spot**

**Enter result of TB skin test or QuantiFERON/T-Spot here:**

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

Results:  Positive  Negative

Provider/Nurse Practitioner Name & Credentials (Please Print)

Office Address

City, State

Zip Code

*This information must be legible and include professional credentials*

Provider/Nurse Signature

Date

- 2-step PPD or QuantiFERON blood test or T-spot blood test is required within 4 months of the start of your program (interval between the two steps should be at least 1-3 weeks)
- The QuantiFERON/T-Spot or one-step TB (Mantoux) Test must be performed ANNUALLY throughout the program.
- If chest x-ray is needed, you must attach a copy of the results with this form. Documentation must include date x-ray was read and the name and credentials of the individual who read the x-ray. Chest x-ray must have been performed within the past year.
- Please note, if the result is positive, the provider/nurse practitioner will need to provide you with a letter of clearance to determine appropriate follow up.

*\*Results from your electronic medical record information system (MyChart, etc.) may be substituted in lieu of this form. Once completed, upload relevant form(s) to your Exxat profile.*

**Place Provider's Office Stamp in the Box on the Right for Validation**

*Place Provider's Stamp in this Box  
for Validation\**



Cleveland State University ▪ School of Nursing  
**HEPATITIS B VACCINE SERIES**

Student Name: \_\_\_\_\_ CSU ID #: \_\_\_\_\_

**Have you completed a series of Hepatitis B immunization?**

**Please provide proof of 3-step OR 2-step Hep B vaccine series:**

		<i>Place Provider's Stamp in this Box for Validation*</i>
Date of Hepatitis B Dose #1	Provider/Nurse Practitioner Signature	
		<i>Place Provider's Stamp in this Box for Validation*</i>
Date of Hepatitis B Dose #2	Provider/Nurse Practitioner Signature	
		<i>Place Provider's Stamp in this Box for Validation*</i>
Date of Hepatitis B Dose #3	Provider/Nurse Practitioner Signature	

Provider/Nurse Practitioner Name & Credentials (Please Print)	Office Address	City, State	Zip Code
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*This information must be legible and include professional credentials*

Provider/Nurse Signature	Date
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**EVIDENCE OF EACH DOSE MUST BEAR A VALIDATION STAMP**

*\*Results from your electronic medical record information system (MyChart, etc.) may be substituted in lieu of this form. Once completed, upload relevant form(s) to your Exxat profile.*

Cleveland State University ▪ School of Nursing  
**HEPATITIS B TITER**

Student Name: \_\_\_\_\_ CSU ID #: \_\_\_\_\_

Titer Result:	Provider/Nurse Practitioner Name & Credentials (Please Print):	<i>Place Provider's Stamp in this Box for Validation*</i>
<input type="checkbox"/> Positive <input type="checkbox"/> Negative		
Date of Titer	Provider/Nurse Practitioner Signature	

**If the result is positive, you're done!**

***If not, a 2-dose Hepatitis B series is required followed by a second titer to confirm immunization.***

		<i>Place Provider's Stamp in this Box for Validation*</i>
Date of Hepatitis B Dose #1	Provider/Nurse Practitioner Signature	

		<i>Place Provider's Stamp in this Box for Validation*</i>
Date of Hepatitis B Dose #2	Provider/Nurse Practitioner Signature	

***Upon completion of the 2-dose Hepatitis B series, a second titer is required to confirm immunization.***

Titer Result:	Provider/Nurse Practitioner Name & Credentials (Please Print):	<i>Place Provider's Stamp in this Box for Validation*</i>
<input type="checkbox"/> Positive <input type="checkbox"/> Negative		
Date of Titer	Provider/Nurse Practitioner Signature	

***Please note, if the titer remains negative, the provider/nurse practitioner will need to determine follow up as appropriate and provide the School of Nursing with the plan.***

Provider/Nurse Practitioner Name & Credentials (Please Print)	Office Address	City, State	Zip Code
<i>This information must be legible and include professional credentials</i>			

Provider/Nurse Signature	Date
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**EVIDENCE OF EACH DOSE MUST BEAR A VALIDATION STAMP**

*\*Results from your electronic medical record information system (MyChart, etc.) may be substituted in lieu of this form. Once completed, upload relevant form(s) to your Exxat profile.*

## COVID-19 VACCINATION

Student Name: \_\_\_\_\_ CSU ID #: \_\_\_\_\_

**Please indicate your status below:**

### MODERNA

- I received the **Moderna Monovalent 1<sup>st</sup>** vaccine on \_\_\_\_\_  
*Date of vaccination*
- I received the **Moderna Monovalent 2<sup>nd</sup>** vaccine on \_\_\_\_\_  
*Date of vaccination*
- I received the **Moderna Monovalent** booster on \_\_\_\_\_  
*Date of vaccination*

- I received the **Moderna Bivalent** vaccine on \_\_\_\_\_  
*Date of vaccination*

### PFIZER

- I received the **Pfizer 1<sup>st</sup>** vaccine on \_\_\_\_\_  
*Date of vaccination*
- I received the **Pfizer 2<sup>nd</sup>** vaccine on \_\_\_\_\_  
*Date of vaccination*
- I received the **Pfizer** booster on \_\_\_\_\_  
*Date of vaccination*

- I received the **Pfizer Bivalent** vaccine on \_\_\_\_\_  
*Date of vaccination*

### JOHNSON & JOHNSON / JANSSEN

- I received the single-dose J&J vaccine on \_\_\_\_\_  
*Date of vaccination*

Provider/Nurse Practitioner Name & Credentials (Please Print)	Office Address	City, State	Zip Code
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*This information must be legible and include professional credentials*

*Place Provider's Stamp in this Box for Validation\**

Provider/Nurse Signature

Date

*\*Results from your electronic medical record information system (MyChart, etc.) may be substituted in lieu of this form.  
Once completed, upload relevant form(s) to your Exxat profile.*

Cleveland State University ▪ School of Nursing  
**MEASLES MUMPS RUBELLA (MMR) IMMUNIZATION**

Student Name: \_\_\_\_\_ CSU ID #: \_\_\_\_\_

**Have you received your MMR immunization?**

**1. If so, have a titer drawn and complete the following:**

Measles (Rubeola)	Mumps	Rubella	<i>Place Provider's Stamp in this Box for Validation*</i>
<input type="checkbox"/> Positive <input type="checkbox"/> Negative	<input type="checkbox"/> Positive <input type="checkbox"/> Negative	<input type="checkbox"/> Positive <input type="checkbox"/> Negative	
Provider/Nurse Practitioner Name & Credentials (Please Print):			
Date of Titer	Provider/Nurse Practitioner Signature		

*If the results are positive, you're done!*

**2. If any of the results are negative, re-immunization is required followed by a second titer to confirm immunization:**

Measles Mumps Rubella (MMR) Booster		<i>Place Provider's Stamp in this Box for Validation*</i>
Provider/Nurse Practitioner Name & Credentials (Please Print):		
Date of MMR Booster	Provider/Nurse Practitioner Signature	

**3. Upon completion of the re-immunization, a second titer is required to confirm immunization.**

Measles (Rubeola)	Mumps	Rubella (Measles)	<i>Place Provider's Stamp in this Box for Validation*</i>
<input type="checkbox"/> Positive <input type="checkbox"/> Negative	<input type="checkbox"/> Positive <input type="checkbox"/> Negative	<input type="checkbox"/> Positive <input type="checkbox"/> Negative	
Provider/Nurse Practitioner Name & Credentials (Please Print):			
Date of Titer	Provider/Nurse Practitioner Signature		

***Please note, if the titer remains negative, the provider/nurse practitioner will need to determine follow up as appropriate and provide the School of Nursing with the plan.***

Provider/Nurse Practitioner Name & Credentials (Please Print)	Office Address	City, State	Zip Code
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*This information must be legible and include professional credentials*

Provider/Nurse Signature	Date
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**EVIDENCE OF EACH TITER/BOOSTER MUST BEAR A VALIDATION STAMP**

*\*Results from your electronic medical record information system (MyChart, etc.) may be substituted in lieu of this form. Once completed, upload relevant form(s) to your Exxat profile.*

Cleveland State University ▪ School of Nursing  
**VARICELLA (CHICKEN POX) IMMUNIZATION**

Student Name: \_\_\_\_\_ CSU ID #: \_\_\_\_\_

**Have you received the Varicella (Chicken Pox) immunization or had chicken pox?**

**1. If so, have a titer drawn and complete the following:**

Titer Result:	Provider/Nurse Practitioner Name & Credentials (Please Print):	<i>Place Provider's Stamp in this Box for Validation*</i>
<input type="checkbox"/> Positive <input type="checkbox"/> Negative		
Date of Titer	Provider/Nurse Practitioner Signature	

*If the result is positive, you're done!*

**2. If the above result is negative, re-immunization is required followed by a second titer to confirm immunization:**

<b>Varicella (Chicken Pox) Booster</b>		<i>Place Provider's Stamp in this Box for Validation*</i>
Provider/Nurse Practitioner Name & Credentials (Please Print):		
Date of MMR Booster	Provider/Nurse Practitioner Signature	

**3. Upon completion of the re-immunization, a second titer is required to confirm immunization.**

Titer Result:	Provider/Nurse Practitioner Name & Credentials (Please Print):	<i>Place Provider's Stamp in this Box for Validation*</i>
<input type="checkbox"/> Positive <input type="checkbox"/> Negative		
Date of Titer	Provider/Nurse Practitioner Signature	

**Please note, if the titer remains negative, the provider/nurse practitioner will need to determine follow up as appropriate and provide the School of Nursing with the plan.**

Provider/Nurse Practitioner Name & Credentials (Please Print)	Office Address	City, State	Zip Code
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*This information must be legible and include professional credentials*

Provider/Nurse Signature	Date
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**EVIDENCE OF EACH TITER/BOOSTER MUST BEAR A VALIDATION STAMP**

*\*Results from your electronic medical record information system (MyChart, etc.) may be substituted in lieu of this form. Once completed, upload relevant form(s) to your Exxat profile.*

## SEASONAL INFLUENZA (FLU SHOT) VACCINATION

**\*STUDENTS BEGINNING SPRING SEMESTER MUST HAVE THIS COMPLETED BEFORE THE START OF THE SEMESTER**

**FLU SEASON TYPICALLY BEGINS LATE AUGUST - VACCINATIONS ARE NOT AVAILABLE BEFORE THIS TIME**

Student Name: \_\_\_\_\_ CSU ID #: \_\_\_\_\_

**Please provide the following:**

Date Administered:	_____
Lot #:	_____
Expiration Date:	_____
Site of Injection:	<input type="checkbox"/> Left Deltoid <input type="checkbox"/> Right Deltoid
Administered by:	_____
	Signature
	_____
	Please Print Name
	_____
	Office Address
	City, State
	Zip Code

*This information must be legible and include professional credentials*

**Documentation must be submitted to the School of Nursing by SEPTEMBER 15<sup>th</sup> Annually**

*In the case of an allergic reaction to the flu vaccine, an official letter from the provider must be submitted annually listing the diagnosis and the provider's contact information. Clinical or fieldwork assignments will be pending the availability of a facility/site that allows Flu vaccine exemptions for students.*

*\*Results from your electronic medical record information system (MyChart, etc.) may be substituted in lieu of this form. Once completed, upload relevant form(s) to your Exxat profile.*

**Place Provider's Office Stamp in the Box on the Right for Validation**

*Place Provider's Stamp in this Box  
for Validation\**

## INSURANCE REQUIREMENTS AND FORMS

### **Student Liability Insurance**

Cleveland State University covers students through a blanket student liability insurance plan when they are enrolled in the nursing program while participating in clinical experiences under the direction, supervision, and control of the Cleveland State University School of Nursing. The limits of liability are \$1,000,000 each claim, \$3,000,000 aggregate.

All students enrolled in a CSU Baccalaureate Nursing Program will be covered with this insurance when the Semester registration is paid.

### **Health Insurance Verification**

Each student must carry some form of health insurance for his/her own protection.

The student may obtain insurance from a private agency or participate in CSU's Student Health Insurance Plan. Insurance plan brochures are available in the Health & Wellness Services Department, 2112 Euclid Avenue, Room 205 (IM Building) or on their website:

<https://www.csuohio.edu/health/health-insurance-information>

***Please document below information related to your health insurance coverage.***

Name			CSU ID #
Last Name			First Name
Middle Initial			

Policy Holder's Name: \_\_\_\_\_  
(if different from student)

Company Name: \_\_\_\_\_

Dates of Coverage: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Group Number: \_\_\_\_\_

***\*Once completed, upload relevant form and copy of health insurance card to your Exxat profile.***

## Background Check

Every student must complete a background check BCI/FBI. Please consult with your state background check agency as to the best way to go about performing a BCI/FBI background check. If possible, results should be mailed to you so you may scan and upload them into Exxat. If a reason for the background check is required, as it is in Ohio, use the reason *entering nursing school*.

Criminal records check must be uploaded to Exxat by the student and must state no convictions on file for this applicant. If convictions are on file, must be reviewed by SON designee.

Exxat invite will be sent to students to begin clearances. For Graduate Nursing students, this invite will be sent the Monday before the first term starts. **The deadline to submit requirements is 12 weeks after the invitation is sent.** Students should be advised that Exxat can take 14 days to review submissions, and should, therefore, not wait until the last minute to submit requirements. An annual fee is required to use Exxat (paid directly by student to Exxat prior to uploading health data).





## **CRIMINAL BACKGROUND CHECKING & FINGERPRINTING**

College Advising Office (ESSC) Julka Hall JH 170,  
Monday-Friday, 9:00-4:30; hours are subject change Phone: 216-687-4625 Fax:  
216-687-9284  
Email: [coe.advising@csuohio.edu](mailto:coe.advising@csuohio.edu)

### **Fingerprinting Procedure**

All background checks at Cleveland State University are processed through the Office of Field Services located at Julka Hall, Room 187. Please visit their website for more information.

#### **Need payment and ID to be fingerprinted.**

- ID can be Driver's license or State of Ohio ID
- Cost is \$30.00 each or \$60.00 for both FBI & BCI.

#### **STEP 1: Submitting payment**

##### **Paying by Credit Card**

- Pay at the ESSC (JH 170)

#### **STEP 2: Education Advising Office**

- Bring cashier's receipt and driver's license or State of Ohio ID.
- Complete electronic fingerprinting.
- Results are available within 2-4 weeks.

#### **Off Campus/In-State – Identify fingerprint locations on National WebCheck**

[www.OhioAttorneyGeneral.gov/WebCheck](http://www.OhioAttorneyGeneral.gov/WebCheck) or call 1-800-282-0515

#### **Off Campus/Out-of-State – Identify fingerprint locations on the internet (search for your state's authorized Civilian and Federal Background Check Center)**



**DAVE YOST**  
OHIO ATTORNEY GENERAL



Identification Quality Assurance  
Office 740-845-2113  
Fax 866-400-5011

## NONCRIMINAL JUSTICE APPLICANT'S RIGHTS

As an applicant who is the subject of a national fingerprint-based criminal history record check for a noncriminal justice purpose (such as an application for a job or license, an immigration or naturalization matter, security clearance, or adoption), you have certain rights which are discussed below.

- You must be notified by the requesting agency that your fingerprints will be used to check the criminal history records of the FBI.
- If you have a criminal history record, the officials making a determination of your suitability for the job, license, or other benefit must provide you the opportunity to complete or challenge the accuracy of the information in the record.
- The officials must advise you that the procedures for obtaining a change, correction, or updating of your criminal history record are set forth at Title 28, Code of Federal Regulations (CFR), Section 16.34.
- If you have a criminal history record, you should be afforded a reasonable amount of time to correct or complete the record (or decline to do so) before the officials deny you the job, license, or other benefit based on information in the criminal history record.<sup>1</sup>

You have the right to expect that officials receiving the results of the criminal history record check will use it only for authorized purposes and will not retain or disseminate it in violation of federal statute, regulation or executive order, or rule, procedure or standard established by the National Crime Prevention and Privacy Compact Council.<sup>2</sup>

If agency policy permits, the officials may provide you with a copy of your FBI criminal history record for review and possible challenge. If agency policy does not permit it to provide you a copy of the record, you may obtain a copy of the record by submitting fingerprints and a fee to the FBI. Information regarding this process may be obtained at <https://www.fbi.gov/services/cjis/compact-council/guiding-principles-noncriminal-justice-applicants-privacy-rights>.

If you decide to challenge the accuracy or completeness of your FBI criminal history record, you should send your challenge to the agency that contributed the questioned information to the FBI. Alternatively, you may send your challenge directly to the FBI. The FBI will then forward your challenge to the agency that contributed the questioned information and request the agency to verify or correct the challenged entry. Upon receipt of an official communication from that agency, the FBI will make any necessary changes/corrections to your record in accordance with the information supplied by that agency. (See 28 CFR 16.30 through 16.34.)

If you need additional information or assistance, please contact the Identification Quality Assurance Unit at 740-845-2113 or [NationalWebcheck@ohioattorneygeneral.gov](mailto:NationalWebcheck@ohioattorneygeneral.gov).

<sup>1</sup> See 28 CFR 50.12(b).

<sup>2</sup> See 5 U.S.C. 552a(b); 28 U.S.C. 534(b); 42 U.S.C. 14616, Article IV(c); 28 CFR 20.21(c), 20.33(d) and 906.2(d).

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1560 State Route 56 SW | London, OH | 43140  
[www.OhioAttorneyGeneral.gov](http://www.OhioAttorneyGeneral.gov)

**For Fingerprinting Use At The CSU School of Nursing Main Office ONLY:**

## Request for a Background Check via Electronic Fingerprinting

- |   |   |
|---|---|
| <input checked="" type="checkbox"/> Undergraduate (BSN, ABSN) | <input checked="" type="checkbox"/> BCI |
| <input type="checkbox"/> Graduate (MSN or DNP)                | <input checked="" type="checkbox"/> FBI |
| <input type="checkbox"/> Faculty                              |   |
| <input type="checkbox"/> Community Health Worker              |   |

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ SSN \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

### FBI Background Check Only

Sex \_\_\_\_\_ Race \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Hair Color \_\_\_\_\_ Eye Color \_\_\_\_\_

Reason for Background Check (4723.09):

Address for results to be mailed to:

- |   |   |
|---|---|
| <input checked="" type="checkbox"/> New Admit Nursing Student | <input checked="" type="checkbox"/> CSU School of Nursing |
| <input type="checkbox"/> Graduating Nursing Senior            | <input type="checkbox"/> Ohio Board of Nursing            |
| <input type="checkbox"/> Faculty                              | <input type="checkbox"/> Other (see below)                |
| <input type="checkbox"/> Community Health Worker              |   |

*I certify that the personal identifiers provided on this form are accurate and I voluntarily and knowingly authorize the Ohio Bureau of Criminal Identification & Investigations to conduct a criminal records check for the information relating to me.*

### To be Completed for *OUT OF STATE* Board Licensure Only

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*I also voluntarily and knowingly authorize BCI&I to disseminate criminal arrest, conviction and juvenile delinquency adjudication records to **Cleveland State University** and/or to **the requested Board of Nursing**. I voluntarily and knowingly release and discharge the Ohio Attorney General's office, BCI&I and their employees from all claims and liability related to this authorized criminal record review and dissemination.*

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

ShopNet Payment Reference Number: \_\_\_\_\_

### For internal use only:

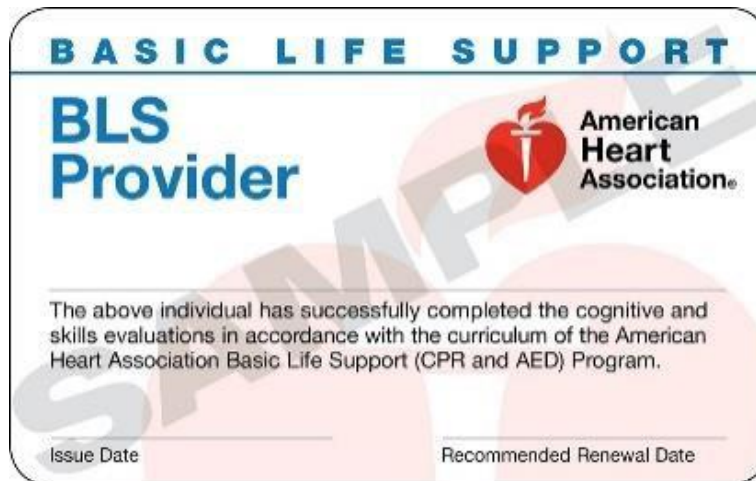
Administrator's Initials \_\_\_\_\_ Date Performed \_\_\_\_\_

Date Results Received \_\_\_\_\_

## CARDIOPULMONARY RESUSCITATION

All students are required to maintain CPR certification – Basic Life Support (BLS) for the Health Care Provider from the American Heart Association **only**. *Online courses are not accepted.*

**NO OTHER CERTIFICATION IS ACCEPTABLE.**



- You must submit documentation of current **CPR-BLS for the Healthcare Provider** certification
- If you have already completed the correct course within the past 12 months, please provide documentation (24 months from the date of certification, it must be renewed)
- Your **CPR-BLS for the Healthcare Provider** **MUST BE** renewed every 24 months throughout the program. A copy of your 2-year re-certification card must be submitted upon completion of the course **biennially**.

### CPR Course Locations

**CSU Campus:** Sigma Theta Tau International  
Nu Delta Chapter  
Website: <https://health.csuohio.edu/information/sigma-theta-tau-international-advising>  
Email: To inquire about upcoming CPR, please contact Dr. Niederriter at [j.niederriter@csuohio.edu](mailto:j.niederriter@csuohio.edu)

**Off Campus :** CPR Ohio  
*Ohio*  
Website: <https://www.cprohio.com>  
Phone: 855-236-7230 or 216-251-0747  
Location: 21245 Lorain Road, Suite 208, Fairview Park, OH 44126

**Off Campus:** Contact any local provider authorized by the [American Heart Association](#)  
*Outside Ohio*

***\*Once completed, upload a copy of BLS certification to your Exxat profile.***

## UNIFORM INFORMATION

Basic and Accelerated students will need to have a lab coat and full uniform. The lab coat and uniforms must be ordered from *Affordable Uniforms*. Lab coat and uniforms must be ordered at least 6 weeks prior to clinical orientation. In addition to the locations listed below, *Affordable Uniforms* can also be found in Columbus, Dayton, and Stow.

### Locations:

4916 Turney Road  
Garfield Heights, OH 44125  
216-271-9597

7647 Mentor Avenue  
Mentor, OH 44060  
440-918-9800

24777 Lorain Road  
North Olmsted, OH 44070  
440-801-1520

You will need to purchase the following items. Items listed below with an asterisk (\*) must be purchased through *Affordable Uniforms*. Other items can be purchased from the company or through your own sources.

### WOMEN

- **Uniform** (white skirt or pant style suit)
- **Lab coat**

### MEN

- **Uniform shirt and white trousers**
- **Lab coat**

### BOTH

- **CSU Name Pin**
- **CSU Student Nurse Patch**  
*one for each uniform and lab coat*
- **Stethoscope**
- **White Nurse's Shoes**  
*no canvas tennis shoes, open heel, or clogs may be worn. All-white leather tennis shoes without color markings are allowed. Shoes must have closed toe and heel to meet OSHA requirements.*

### ***Please note:***

- Your uniform and lab coat do not come with the CSU patch sewn on. You will need to purchase separate patches (which are available at *Affordable Uniforms*) and sew them on the upper left sleeve of each uniform and lab coat. *Affordable Uniforms* can sew the patches for an extra charge.
- Be sure to allow plenty of room in your tops to be able to move your arms freely, even if wearing a sweater.
- Uniforms are paid for at the time order is placed.
- NUR 313 Psych Mental Health and NUR 414 Community Health Nursing have separate uniform attire that is to be worn while participating in Service-Learning Activities in the community. The approved polo shirt is available at the CSU Bookstore.



## Cleveland State University Nursing Uniform Order Form

Name: \_\_\_\_\_ Date: \_\_\_\_\_

4916 Turney Road  
Garfield Hts. 44125



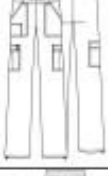


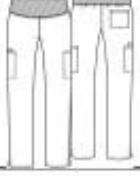

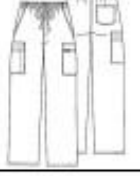
24777 Lorain Road  
North Olmsted, 44077

Phone Number: \_\_\_\_\_



7647 Mentor Ave.  
Mentor, 44060

Order online at:  
[affuniforms.com/csu-nursing](http://affuniforms.com/csu-nursing)

Address: \_\_\_\_\_

Style		Sizes	Size	Qty.	Student Price	Total
	<b>Women's Top</b> <i>Cherokee Workwear</i> 4727 Two Pocket Top	XXS-XL			\$20.69	
		2X-5X			\$23.39	
	<b>Women's Pant</b> <i>Cherokee Workwear</i> 4044 Drawstring Waist Pant Regular Inseam 31" Petite Inseam 28" Tall Inseam 33.5"	XXS-XL			\$23.39	
		2X-5X			\$26.09	
		Petite XXS-XL			\$23.39	
		Petite 2X			\$26.09	
		Tall XS-XL			\$25.39	
		Tall 2X			\$28.09	
	<b>Women's Pant</b> <i>Cherokee Workwear</i> 4005 Elastic Waist Pant Regular Inseam 31" Petite Inseam 28" Tall Inseam 33.5"	XXS-XL			\$23.39	
		2X-5X			\$26.09	
		Petite XXS-XL			\$23.39	
		Petite 2X			\$26.09	
		Tall XS-XL			\$25.39	
		Tall 2X			\$28.09	
	<b>Women's Skirt</b> <i>Cherokee Workwear</i> WW510 Elastic Waist Skirt	XS-XL			\$19.79	
		2X-5X			\$22.49	
	<b>Maternity Top</b> <i>Cherokee Workwear</i> WW685 Two Pocket Top	XS-XL			\$27.89	
		2X-3X			\$30.59	
	<b>Maternity Pant</b> <i>Cherokee Workwear</i> WW220 Elastic Tummy Band Regular Inseam 31" Petite Inseam 28.5" Tall Inseam 34"	XS-XL			\$27.89	
		2X-3X			\$30.59	
		Petite XS-XL			\$27.89	
		Petite 2X			\$30.59	
		Tall XS-XL			\$29.89	
	<b>Unisex Top</b> <i>Cherokee Workwear Premium</i> 4725 Three Pocket Top	XS-XL			\$20.69	
		2X-5X			\$23.39	
	<b>Men's Pant</b> <i>Cherokee Workwear Premium</i> 4243 Elastic Waist Pant Regular Inseam 31"	XS-XL			\$25.19	
		2X-5X			\$26.09	

Cleveland State University ▪ School of Nursing

	<b>Women's Lab Coat</b> Wonder Wink 7402 Lab Coat Length: 38"	XXS-XL			\$23.39
		2X-5X			\$26.99
	<b>Unisex Lab Coat</b> Wonder Wink 7302 Lab Coat Length: 42"	XS-XL			\$23.39
		2X-5X			\$26.99
<b>Patches</b> - CSU Student Patches					\$5.99
<b>Sewing</b> - Sewing for Student Patches to Uniforms					\$5.99
<b>Name Badge:</b> First Name _____, Student Nurse					\$8.99
<b>Students will need the following:</b>					
Stethoscope <i>Multiple Options In Store</i>					19.99 - 109.99
Hemostats <i>Multiple Options In Store</i>					6.99 - 9.99
Penlight <i>Multiple Options In Store</i>					5.99 - 9.99
Scissors <i>Multiple Options In Store</i>					5.99 - 9.99
Subtotal					
(if applicable) Shipping \$7.99					
Sales Tax 8%					
Total					



Directions and store hours can be found at [affuniforms.com](http://affuniforms.com).

Orders can be placed in-store, by phone, and online at [affuniforms.com/csu-nursing](http://affuniforms.com/csu-nursing)

If you're sending your order by mail or fax please include your payment information below

Billing Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Billing Address: \_\_\_\_\_

Credit Card Number: \_\_\_\_\_

Expiration: \_\_\_\_\_ 3 - 4 Digit Security Code (back of card) \_\_\_\_\_

## PSYCH MENTAL HEALTH and COMMUNITY HEALTH NURSING UNIFORM ATTIRE

- Approved polo shirt is available at Viking Outfitters / CSU Bookstore
- Khaki pants or khaki shirt are to be worn
- NO shorts, capris, or leggings
- Closed toe shoe and socks/stockings are to be worn
- This attire is to be worn during service learning & volunteering for events



2121 Euclid Avenue  
Student Center, Rm. 105  
Cleveland, OH 44115-2214  
216-687-2128

### Polo Shirt Information:

- Antigua Elite Tipped Collar
- Color: Pine
- CSU logo embroidered in white on left chest
- Note: The polos are kept behind the sales desk for nursing students at a reduced cost of \$28.00 (ask for the manager-on-duty if there are issues)

### When to Purchase:

- Accelerated BSN Program – prior to the 2<sup>nd</sup> semester
- Traditional BSN Program – prior to the 3<sup>rd</sup> semester







Name: \_\_\_\_\_

Email: \_\_\_\_\_

Phone #: \_\_\_\_\_



School  
of Nursing

Green Polo Shirts Order Form

**MEN'S POLO -- \$30.00 ea.**

Size	Quantity
SM	_____
MD	_____
LG	_____
XL	_____
2XL	_____
3XL	_____
4XL	_____
5XL	_____

**WOMEN'S POLO -- \$28.00 ea.**

Size	Quantity
XS	_____
SM	_____
MD	_____
LG	_____
XL	_____
2XL	_____
3XL	_____

*To be completed upon pickup:*

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

TXN #: \_\_\_\_\_



# School of Nursing

## COLLEGE OF HEALTH

### CHECKLIST – STUDENT HEALTH DATA

- |                          |                   |  |
|--------------------------|-------------------|--|
| <input type="checkbox"/> | Hepatitis B       | Documentation of vaccine series  |
| <input type="checkbox"/> | Hepatitis B       | Documentation of positive titer  |
| <input type="checkbox"/> | Flu Vaccine       | Documentation of completion each year  |
| <input type="checkbox"/> | Varicella         | Documentation of positive titer  |
| <input type="checkbox"/> | MMR               | Documentation of positive titer  |
| <input type="checkbox"/> | TB                | Documentation of the 2-step test or QuantiFERON or T-Spot <u>upon admission</u> and 1-step or QuantiFERON/T-Spot every year thereafter |
| <input type="checkbox"/> | Tdap/DT           | Documentation of immunization complete   |
| <input type="checkbox"/> | Health Exam       | Documentation complete   |
| <input type="checkbox"/> | COVID Vaccination | Documentation complete   |

### CHECKLIST – OTHER REQUIREMENTS

- CPR-BLS certification is up-to-date and remains current
- Background Check
- Health Insurance Verification complete
- CSU uniform order complete
- Undergraduate Prelicensure Student Handbook documents to be uploaded to student's Exxat profile:
  - *Memorandum of Understanding*
  - *Media Release & Copyright Permission*
  - *Informed Consent, Assumption of Risk, and Release of Records*
  - *Safety & Technical Standards Acknowledgment*
  - *Drug Screen Acknowledgement*