School of Nursing

PROGRAM AND HEALTH REQUIREMENTS FOR MSN STUDENTS

Revised 3/10/23; 3/16/23; 3/22/23; 4/3/23; 4/12/23; 4/26/2023; 5/1/2023; 5/25/2023; 6/26/2023; 8/9/2023; 8/10/2023; 8/16/2023

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.

Graduate Student Handbook:

1. Go to the School of Nursing homepage at: https://nursing.csuohio.edu/information/information-for-current-students
2. Read the *Graduate Prelicensure Student Handbook* completely
3. The following documents from the *Graduate 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.

- ☐ Tdap
- ☐ Tuberculin (TB/Mantoux) Skin Test *or* QuantiFERON *or* T-Spot *or* Chest X-Ray Verification
- ☐ Hepatitis B Vaccine Series
- ☐ Hepatitis B Titer
- ☐ COVID-19 Vaccination
- ☐ Measles Mumps Rubella (MMR) Titer
- ☐ Varicella Titer
- ☐ Seasonal Influenza Vaccination

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

Additional Information Required:

- ☐ Health Insurance Verification
- ☐ CPR Certification
- ☐ Fingerprinting and Background Check Information
- ☐ 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.

Revised 3/10/23; 3/16/23; 3/22/23; 4/3/23; 4/12/23; 4/26/2023; 5/1/2023; 5/25/2023; 6/26/2023; 8/9/2023; 8/10/2023; 8/16/2023

Welcome CSU Nursing Students!

We are here to help you with your medical admission requirements

Health & Wellness Services

Center for Innovations in Medical Professions (CIMP)
2112 Euclid Ave, Room 205
Monday – Friday, 8am – 5pm
(across from the Student Center)

HEALTH SERVICES PRICE LIST

(effective 7/22/2021 – all prices subject to change pending market price & availability)

Physical Examinations	$30.00	Hepatitis B Titer	$22.00
TB Tests (including reading of test)	$10.00	Hepatitis B (3 shots over 6 months)	$45.00
Varicella (Chicken Pox) Titer	$12.00	Measles Titer	$12.00
Tdap	$40.00	Mumps Titer	$12.00
Flu vaccine (injection) regular	$25.00	Rubella Titer	$12.00
Flu vaccine (injection) high dose	$40.00	MMR Vaccine	$85.00

For a complete list of services & current fees visit: https://www.csuohio.edu/health/self-pay-fee-schedule

Schedule your appointment:
216-687-3649

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.

Revised 3/10/23; 3/16/23; 3/22/23; 4/3/23; 4/12/23; 4/26/2023; 5/1/2023; 5/25/2023; 6/26/2023; 8/9/2023; 8/10/2023; 8/16/2023

Cleveland State University ▪ School of Nursing

IMMUNIZATION STATUS

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

Tetanus, Diphtheria, and Pertussis	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.
MEASLES MUMPS RUBELLA (MMR)	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 ***Measles Mumps Rubella (MMR) Immunization*** form. *Rubella* also known as German Measles; *Rubeola* also known as English Measles.
VARICELLA	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 ***Varicella (Chicken Pox) Immunization*** form.
Tuberculin (TB) (MANTOUX) TEST	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 ***QuantiFERON or Tuberculin Mantoux Skin Test (or Chest X-Ray)*** 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.
HEPATITIS 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 ***Hepatitis B Immunization*** form. The vaccine is also available at CSU Health & Wellness Services.
SEASONAL INFLUENZA (FLU) VACCINATION	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 ***Seasonal Influenza (Flu Shot) Vaccination*** form and submitted by October 15th ANNUALLY to be qualified to continue or begin clinical. ***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.**
COVID-19 VACCINATON	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 csuschoolofnursing@csuohio.edu for more information. **Clinical or fieldwork assignments will be pending the availability of a facility/site that allows Covid-19 vaccine exemptions for students.**

Revised 3/10/23; 3/16/23; 3/22/23; 4/3/23; 4/12/23; 4/26/2023; 5/1/2023; 5/25/2023; 6/26/2023; 8/9/2023; 8/10/2023; 8/16/2023

Cleveland State University ▪ School of Nursing

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**

Revised 3/10/23; 3/16/23; 3/22/23; 4/3/23; 4/12/23; 4/26/2023; 5/1/2023; 5/25/2023; 6/26/2023; 8/9/2023; 8/10/2023; 8/16/2023

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**

Revised 3/10/23; 3/16/23; 3/22/23; 4/3/23; 4/12/23; 4/26/2023; 5/1/2023; 5/25/2023; 6/26/2023; 8/9/2023; 8/10/2023; 8/16/2023

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:

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

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

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.*

Revised 3/10/23; 3/16/23; 3/22/23; 4/3/23; 4/12/23; 4/26/2023; 5/1/2023; 5/25/2023; 6/26/2023; 8/9/2023; 8/10/2023; 8/16/2023

Cleveland State University ▪ School of Nursing

HEPATITIS B TITER

Student Name: _____ CSU ID #: _____

Titer Result:	Provider/Nurse Practitioner Name & Credentials (Please Print):	*Place Provider's Stamp in this Box for Validation**
☐ Positive ☐ 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.

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

		*Place Provider's Stamp in this Box for Validation**
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):	*Place Provider's Stamp in this Box for Validation**
☐ Positive ☐ 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

This information must be legible and include professional credentials

Provider/Nurse Signature	Date

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.

Revised 3/10/23; 3/16/23; 3/22/23; 4/3/23; 4/12/23; 4/26/2023; 5/1/2023; 5/25/2023; 6/26/2023; 8/9/2023; 8/10/2023; 8/16/2023

Cleveland State University ▪ School of Nursing

COVID-19 VACCINATION

Student Name: _____ CSU ID #: _____

Please indicate your status below:

MODERNA

☐ I received the **Moderna Monovalent** 1st vaccine on _____
Date of vaccination

☐ I received the **Moderna Monovalent** 2nd 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** 1st vaccine on _____
Date of vaccination

☐ I received the **Pfizer** 2nd 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	
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.*

Revised 3/10/23; 3/16/23; 3/22/23; 4/3/23; 4/12/23; 4/26/2023; 5/1/2023; 5/25/2023; 6/26/2023; 8/9/2023; 8/10/2023; 8/16/2023

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	
☐ Positive ☐ Negative	☐ Positive ☐ Negative	☐ Positive ☐ Negative	*Place Provider's Stamp in this Box for Validation**
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	
Provider/Nurse Practitioner Name & Credentials (Please Print):	*Place Provider's Stamp in this Box for Validation**
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)	
☐ Positive ☐ Negative	☐ Positive ☐ Negative	☐ Positive ☐ Negative	*Place Provider's Stamp in this Box for Validation**
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

This information must be legible and include professional credentials

Provider/Nurse Signature	Date

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.*

Revised 3/10/23; 3/16/23; 3/22/23; 4/3/23; 4/12/23; 4/26/2023; 5/1/2023; 5/25/2023; 6/26/2023; 8/9/2023; 8/10/2023; 8/16/2023

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):	
☐ Positive ☐ Negative		*Place Provider's Stamp in this Box for Validation**
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:**

Varicella (Chicken Pox) Booster		
Provider/Nurse Practitioner Name & Credentials (Please Print):		*Place Provider's Stamp in this Box for Validation**
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):	
☐ Positive ☐ Negative		*Place Provider's Stamp in this Box for Validation**
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

This information must be legible and include professional credentials

Provider/Nurse Signature	Date

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.*

Revised 3/10/23; 3/16/23; 3/22/23; 4/3/23; 4/12/23; 4/26/2023; 5/1/2023; 5/25/2023; 6/26/2023; 8/9/2023; 8/10/2023; 8/16/2023

Cleveland State University ▪ School of Nursing

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: ☐ Left Deltoid ☐ 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 15th 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**

Revised 3/10/23; 3/16/23; 3/22/23; 4/3/23; 4/12/23; 4/26/2023; 5/1/2023; 5/25/2023; 6/26/2023; 8/9/2023; 8/10/2023; 8/16/2023

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.

Revised 3/10/23; 3/16/23; 3/22/23; 4/3/23; 4/12/23; 4/26/2023; 5/1/2023; 5/25/2023; 6/26/2023; 8/9/2023; 8/10/2023; 8/16/2023

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).

Revised 3/10/23; 3/16/23; 3/22/23; 4/3/23; 4/12/23; 4/26/2023; 5/1/2023; 5/25/2023; 6/26/2023; 8/9/2023; 8/10/2023; 8/16/2023

Cleveland State University ▪ School of Nursing

CSU College of Health

CRIMINAL BACKGROUND CHECKING & FINGERPRINTING

College Advising Office (ESSC) Julka Hall JH 170,

Monday-Friday, 9:00-4:30; hours are subject change Phone: 216-687-4625Fax:

216-687-9284

Email: 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 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)

Revised 3/10/23; 3/16/23; 3/22/23; 4/3/23; 4/12/23; 4/26/2023; 5/1/2023; 5/25/2023; 6/26/2023; 8/9/2023; 8/10/2023; 8/16/2023

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.[1]

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.[2]

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 .

1 See 28 CFR50.12(b).

2 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).

1560 State Route 56 SW | London, OH | 43140
www.OhioAttorneyGeneral.gov

Revised 3/10/23; 3/16/23; 3/22/23; 4/3/23; 4/12/23; 4/26/2023; 5/1/2023; 5/25/2023; 6/26/2023; 8/9/2023; 8/10/2023; 8/16/2023

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

Request for a Background Check via Electronic Fingerprinting

- ■ Graduate (MSN)
- ☐ Faculty
- ☐ Community Health Worker

- ■ BCI
- ■ FBI

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):

- ■ New Admit Nursing Student
- ☐ Graduating Nursing Senior
- ☐ Faculty
- ☐ Community Health Worker

Address for results to be mailed to:

- ■ CSU School of Nursing
- ☐ Ohio Board of Nursing
- ☐ Other (see below)

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:

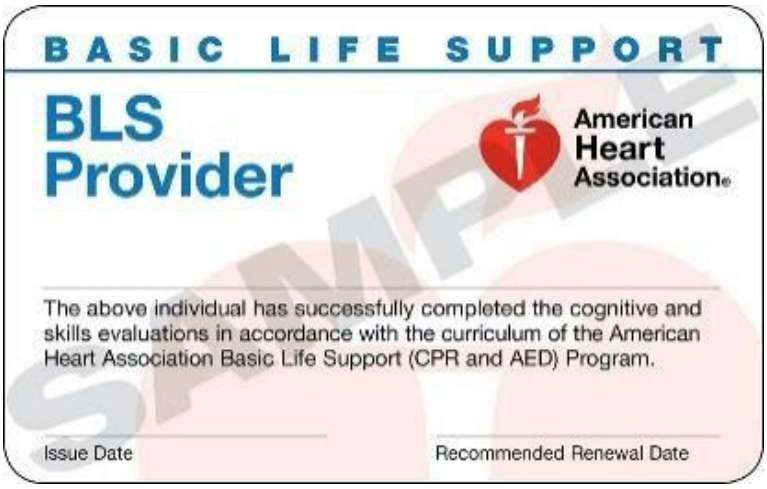
Administrator's Initials _____ Date Performed _____

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

Off Campus : ***Ohio***	CPR 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: ***Outside Ohio***	Contact any local provider authorized by the American Heart Association

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

Revised 3/10/23; 3/16/23; 3/22/23; 4/3/23

School of Nursing

COLLEGE OF HEALTH

CHECKLIST – STUDENT HEALTH DATA

☐	Hepatitis B	Documentation of vaccine series
☐	Hepatitis B	Documentation of positive titer
☐	Flu Vaccine	Documentation of completion each year
☐	Varicella	Documentation of positive titer
☐	MMR	Documentation of positive titer
☐	TB	Documentation of the 2-step test or QuantiFERON or T-Spot upon admission and 1-step or QuantiFERON/T-Spot every year thereafter
☐	Tdap/DT	Documentation of immunization complete
☐	Health Exam	Documentation complete
☐	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
☐ Graduate 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*

Revised 3/10/23; 3/16/23; 3/22/23; 4/3/23; 8/16/2023, 12/5/24