School of Nursing

PROGRAM AND HEALTH REQUIREMENTS FOR BSN 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

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.

- ☐ Health History and Examination
- ☐ 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.

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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.

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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 physician/nurse practitioner or at CSU Health & Wellness Services Department. Complete the personal information and health history sections below and give to your physician/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 PHYSICIAN/NURSE PRACTITIONER

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

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

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

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**

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Student Name: _____ **CSU ID:** _____ **Date:** _____

PHYSICAL EXAMINATION	*ABNORMAL	HEIGHT	WEIGHT	PULSE	B/P
General Appearance					

PHYSICAN'S NOTE OF PHYSICAL & SUMMARY OF SIGNIFICANT FINDINGS	*Abnormal findings must have documentation*	
	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		

Physician/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).*

Physician/Nurse Practitioner Name & Credentials (Please Print) | Office Address | City, State | Zip Code

This information must be legible and include professional credentials

Physician/Nurse Signature | Date

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

*Place Physician's Stamp in this Box for Validation**

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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 physician 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 physician 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 physician 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 physician annually, listing the diagnosis and the physician'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 physician'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.**

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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

Physician/Nurse Practitioner Name & Credentials (Please Print)	Office Address	City, State	Zip Code

This information must be legible and include professional credentials

Physician/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 Physician's Office Stamp in the Box on the Right for Validation

*Place Physician's Stamp in this Box for Validation**

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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

Physician/Nurse Practitioner Name & Credentials (Please Print) | Office Address | City, State | Zip Code

This information must be legible and include professional credentials

Physician/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 physician/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 Physician's Office Stamp in the Box on the Right for Validation

*Place Physician's Stamp in this Box for Validation**

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

Physician/Nurse Practitioner Name & Credentials (Please Print)	Office Address	City, State	Zip Code

This information must be legible and include professional credentials

Physician/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.*

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HEPATITIS B TITER

Student Name: _____ CSU ID #: _____

Titer Result:	Physician/Nurse Practitioner Name & Credentials (Please Print):	*Place Physician's Stamp in this Box for Validation**
☐ Positive ☐ Negative		
Date of Titer	Physician/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 Physician's Stamp in this Box for Validation**
Date of Hepatitis B Dose #1	Physician/Nurse Practitioner Signature	

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

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

Titer Result:	Physician/Nurse Practitioner Name & Credentials (Please Print):	*Place Physician's Stamp in this Box for Validation**
☐ Positive ☐ Negative		
Date of Titer	Physician/Nurse Practitioner Signature	

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

Physician/Nurse Practitioner Name & Credentials (Please Print)	Office Address	City, State	Zip Code

This information must be legible and include professional credentials

Physician/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.

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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

Physician/Nurse Practitioner Name & Credentials (Please Print)	Office Address	City, State	Zip Code	
This information must be legible and include professional credentials				*Place Physician's Stamp in this Box for Validation**

Physician/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.*

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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 Physician's Stamp in this Box for Validation**
Physician/Nurse Practitioner Name & Credentials (Please Print):			
Date of Titer	Physician/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	
Physician/Nurse Practitioner Name & Credentials (Please Print):	*Place Physician's Stamp in this Box for Validation**
Date of MMR Booster	Physician/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 Physician's Stamp in this Box for Validation**
Physician/Nurse Practitioner Name & Credentials (Please Print):			
Date of Titer	Physician/Nurse Practitioner Signature		

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

Physician/Nurse Practitioner Name & Credentials (Please Print)	Office Address	City, State	Zip Code

This information must be legible and include professional credentials

Physician/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.*

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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:	Physician/Nurse Practitioner Name & Credentials (Please Print):	
☐ Positive ☐ Negative		*Place Physician's Stamp in this Box for Validation**
Date of Titer	Physician/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		
Physician/Nurse Practitioner Name & Credentials (Please Print):		*Place Physician's Stamp in this Box for Validation**
Date of MMR Booster	Physician/Nurse Practitioner Signature	

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

Titer Result:	Physician/Nurse Practitioner Name & Credentials (Please Print):	
☐ Positive ☐ Negative		*Place Physician's Stamp in this Box for Validation**
Date of Titer	Physician/Nurse Practitioner Signature	

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

Physician/Nurse Practitioner Name & Credentials (Please Print)	Office Address	City, State	Zip Code

This information must be legible and include professional credentials

Physician/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.*

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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 physician must be submitted annually listing the diagnosis and the physician'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 Physician's Office Stamp in the Box on the Right for Validation

*Place Physician's Stamp in this Box for Validation**

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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.

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ADDITIONAL CLINICAL AGENCY REQUIREMENTS

1. Proof of a clean **Background Check**. If you have been fingerprinted within the last 12 months, please provide an official copy of the results. *Third party background checks are not accepted.*

2. Current **CPR certification** – Basic Life Support (BLS) for the Health Care Provider from the American Heart Association only. *Online courses are not accepted.*

Fingerprinting and Background Check

Civilian (BCI) and Federal (FBI) check results are required

It is in your best interest to complete your background check screening in the School of Nursing office as **early** as possible. **It can take up to 30 days for the results to return to the School of Nursing – you will not be allowed to participate in clinical rotations if the SON does not have a completed background check on file.**

Fingerprinting Locations

CSU Campus: School of Nursing Main Office, IM Building, Room 116. 216-687-3598.
Bring: Proof of payment, Driver's License/State ID, and Request for Background Check form
Time: 9:00am – 4:00pm *Walk-ins available; however, an appointment is preferred.*
Cost: The combined cost of BCI & FBI screenings is $60.00
How to Pay: **Credit/Debit Card via ShopNet**
https://campusnet.csuohio.edu/ShopNet/index.jsp?owner=SONBGRNDCHK&skip=true

How to Pay: **Cash/Check Payments**
Location: Bring this page to the School of Nursing office in IM 116 at 2112 Euclid Avenue, Cleveland, OH 44115
Cost: The combined cost of BCI & FBI screenings is $60.00.

Off Campus: Identify fingerprint locations on National WebCheck
In-State https://www.ohioattorneygeneral.gov/webcheck or call 1-800-282-0515

Off Campus: Identify fingerprint locations on the internet
Out-of-State
- *Google "Where to get fingerprinted in {enter your City/State}*
- Contact your state's authorized Civilian and Federal Background Check center

If you are fingerprinted at an agency other than the School of Nursing, DO NOT use the page provided in this packet. You will be responsible for providing the agency with the EXACT responses listed below. Results not received within 30 days are your responsibility to check the status.

Q: *Reason for background check*
A: *Student entering nursing school*

Q: *Address for results to be mailed*
A: *CSU School of Nursing*
2121 Euclid Avenue, JH 238
Cleveland, OH 44115

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

- ■ Undergraduate (BSN, ABSN)
- ☐ Graduate (MSN or DNP)
- ☐ 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:

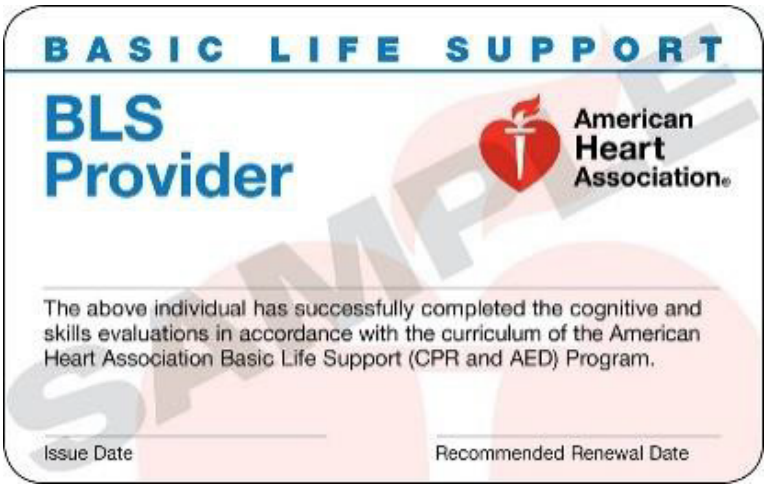
Administrator's Initials _____ Date Performed _____

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

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.

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

Affordable UNIFORMS
The Scrub Superstore

4916 Turney Road
Garfield Hts. 44125

24777 Lorain Road
North Olmsted, 44077

7647 Mentor Ave.
Mentor, 44060

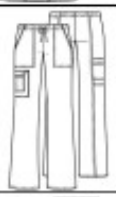
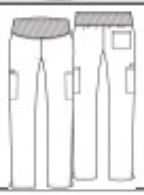
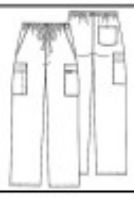
Order online at:
affuniforms.com/csu-nursing

Cleveland State University
Nursing Uniform Order Form

Name: _____ Date: _____

Phone Number: _____

Address: _____

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

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

Directions and store hours can be found at affuniforms.com.

Orders can be placed in-store, by phone, and online at 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) _____

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

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

VIKING OUTFITTERS

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 2nd semester
- ☐ Traditional BSN Program – prior to the 3rd semester

Last revision: 4/4/2023

Cleveland State University ▪ School of Nursing

VIKING OUTFITTERS

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 #: _____

Revised 3/10/23; 3/16/23; 3/22/23; 4/3/23; 8/16/2023

Cleveland State University ▪ School of Nursing

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
- ☐ 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*

Revised 3/10/23; 3/16/23; 3/22/23; 4/3/23; 8/16/2023