School of Nursing
2121 Euclid Avenue, JH 238 • Cleveland, OH 44115-2214 • (216) 687-3598

MASTER OF SCIENCE IN NURSING
PROGRAM AND HEALTH REQUIREMENTS

This packet contains information and forms which must be completed and received by the School of Nursing by the end of the 1st Semester of Enrollment in the Graduate Nursing Program. No 600 level nursing course may be taken if all program requirements are not met.

- **Student Handbook:**
  - Go to the School of Nursing Home page at www.csuohio.edu/nursing
  - Download the Graduate Student Handbook and read completely
  - Print and sign the following sheets:
    - Policy and Procedure **Contract Form** (Page 6)

- **Program and Health Requirement Documentation:**
  - Medical Reports and Forms:
    - Student Information and Medical Requirement
    - Hepatitis B Immunization
    - Measles Mumps Rubella (MMR) Immunization
    - Varicella (Chicken Pox) Immunization
    - Tuberculin Mantoux Skin Test, QuantiFERON TB Gold or Chest X-Ray Verification
    - Tetanus, diphtheria, an pertussis Booster (Tdap)
    - Seasonal Influenza Vaccination
  - Insurance & RN License Requirements and Forms:
    - Student Liability Insurance Information
    - Health Insurance Verification
    - RN License and Registration Verification
  - Additional Clinical Practicum Agency Onboarding Requirements:
    - Fingerprinting and Background Check Information
    - CPR Certification Information

Ways to Submit Your Documents:

U.S. Mail:	**Fax:**
CSU School of Nursing	**CSU School of Nursing**
Attn: Health Data Records	**Attn: Health Data Records**
2121 Euclid Avenue, JH 238	**(216) 687-3556**
Cleveland, OH 44115-2214	

The CSU Health & Wellness Services Department also provides medical services and immunizations inexpensively and most health insurance is accepted. For an appointment, please call 216/687-3649. The Department is located at 2112 Euclid Avenue, Room 205 (IM Building).

STUDENT INFORMATION

This information is strictly confidential. Please print legibly:

Last	First	M. I.	CSU I.D. Number

Street Address:			
	(City)	*(State)*	*(Zip)*

( )	( )	_____/_____/_____
(Home Phone with Area Code)	*(Cell Phone with Area Code)*	*(Birth Date)*

RN License and Registration Verification:

All students enrolled in a CSU Master of Science in Nursing Program are required to maintain a valid active RN License from their state of residence. A valid active RN License Number must be on file in the School of Nursing at all times; the current date must be within the 'Issue' and 'Expiration' date range to be considered active. Please document below information related to your license and update accordingly.

RN License #	State Issued	Date Issued	Expiration Date

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 Master of Science in 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 thier 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, 2nd Floor or on their website: www.gmsouthwest.com/schools/csu

- Please document below information related to your Health Insurance coverage.

Policy Holder's Name (if different from Student): _____

Company Name: _____ Dates of Coverage: _____

Policy Number: _____ Group Number: _____

IMMUNIZATION STATUS – Students must provide adequate documentation of satisfactory immunization status as listed below or by using the following forms:

- Hepatitis B – The School of Nursing strongly recommends that all nursing students receive the Hepatitis B Vaccine. This is to be administered as a series of three injections. The date of each dose is to be recorded on the **Verification of Completed Hepatitis B Immunization** form and submitted to the School of Nursing. The vaccine is also available at the CSU Health & Wellness Services Department. Proof from a physician or health institution of having a positive titer for Hepatitis B is also acceptable.
- MMR (Measles, Mumps, Rubella) –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 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 for varicella (chicken pox) or the vaccination. Proof of immunity must be recorded on the **Verification of Varicella (Chicken Pox) Illness, Immunization or Blood Titer Test Form**.

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

- Tetanus-Diphtheria (TDap) - Students must show proof of booster **within the past ten years** from a physician or health institution. If the student is due for a TD booster at this time, he/she should have it **administered at least two month prior to classes**, with the scheduled date of the immunization noted on the form. Proof of immunity must be recorded on the **Verification of Tetanus-Diphtheria (TDap) Booster Form**.
- Tuberculosis Test Results – A negative TB Mantoux/Two-Step Test report or QuantiFERON TB Gold is required for all students admitted to the Nursing Program with a TB Mantoux/One-Step Test or QuantiFERON TB Gold performed and documentation must be sent ANNUALLY via US Mail to the School of Nursing. A physician will determine the appropriate follow-up for positive results. **The results of the TB Mantox Test or Chest X-Ray should be indicated on the TB Mantoux Skin Test or Chest X-Ray Form**.

  The PPD 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 MetroHealth Medical Center, Cleveland, Ohio The telephone number is (216) 778-8305. An appointment is required. The PPD is also available at the CSU Health & Wellness Services Department.
- Seasonal Influenza (Flu Shot) 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 practicum.

* * *

EVIDENCE OF EACH DOSE/TITER RESULT MUST BEAR A VALIDATION STAMP AND BE SUBMITTED TO THE SCHOOL OF NURSING ONCE IT IS ADMINISTERED.

***An Official Letter from the Physician/Nurse Practitioner detailing the above may be substituted for a validation stamp**.

*An Official Letter from the Physician/Nurse Practitioner detailing the above, or **results from your electronic medical record information system** may be substituted for a validation stamp.

Keep a copy of your documents for your records.

Student Name: _____ CSU ID Number: _____

HEPATITIS B IMMUNIZATION

Have you completed a series of Hepatitis B immunization or have a positive titer? If so, complete one of the following:

1. Series of Hepatitis B immunization. If in progress, submit each injection as it is received.

		Place Physician's Stamp in this Box for Validation*
1st Vaccination Date	Physician/Nurse Practitioner Signature	Place Physician's Stamp in the Above Box for Validation*
		Place Physician's Stamp in this Box For Validation*
2nd Vaccination Date	Physician/Nurse Practitioner Signature	Place Physician's Stamp in the Above Box for Validation*
		Place Physician's Stamp in this Box For Validation*
3rd Vaccination Date	Physician/Nurse Practitioner Signature	Place Physician's Stamp in the Above Box for Validation*

2. **Titer drawn** and complete the following:

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

*An Official Letter from the Physician/Nurse Practitioner detailing the above, or **results from your electronic medical record information system** may be substituted for a validation stamp.

MEASLES MUMPS RUBELLA (MMR) IMMUNIZATION

Have you received your MMR immunization or have a positive titer? If so, complete one of the following:

1. Proof of Vaccination

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)	Place Physician's Stamp in the Above Box for Validation*

2. Proof of Titer Results:

Measles (Rubeola)	**Mumps**	**Rubella (Measles)**	
Titer Result: ☐ Positive ☐ Negative	Titer Result: ☐ Positive ☐ Negative	Titer Result: ☐ 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)		Place Physician's Stamp in the Above Box for Validation*

Student Name: _____ CSU ID Number: _____

VARICELLA (CHICKEN POX) IMMUNIZATION

Have you received your Varicella immunization or have a positive titer? If so, complete one of the following:

1. Proof of Vaccination

Varicella (Chicken Pox) Booster		
Physician/Nurse Practitioner Name & Credentials (Please Print):		Place Physician's Stamp in this Box for Validation*
(Date of Varicella Booster)	(Physician/Nurse Practitioner Signature)	Place Physician's Stamp in the Above Box for Validation*

2. Proof of Titer Results:

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

*An Official Letter from the Physician/Nurse Practitioner detailing the above, or **results from your electronic medical record information system** may be substituted for a validation stamp.

TETANUS-DIPHTHERIA (TDAP) BOOSTER

Must be administered every ten (10) years

Date Administered _____

Lot # _____ Exp. Date _____

Site of Injection: ☐ Left Deltoid ☐ Right Deltoid

Administered by _____
(Signature)

_____
(Please Print Name & Professional Credentials)

_____
Office Address: City, State Zip Code

This information must be legible and include professional credentials

Place Physician's Office Stamp in the Box on the Right for Validation*:
*An Official Letter from the Physician/Nurse Practitioner detailing the above, or **results from your electronic medical record information system** may be substituted for a validation stamp.

Student Name: _____ CSU ID Number: _____

TUBERCULIN QUANTIFERON OR MANTOUX SKIN TEST (OR CHEST X-RAY WHEN NECESSARY)

Mantoux Skin Test/Step One: Date administered: _____ Site of Injection: ☐ Left Arm ☐ Right Arm Date read: _____ Results: ☐ Positive ☐ Negative	***To be performed 1 – 3 weeks after Step One when applicable.*** **Mantoux Skin Test/Step Two:** Date administered: _____ Site of Injection: ☐ Left Arm ☐ Right Arm Date read: _____ Results: ☐ Positive ☐ Negative

QuantiFERON

Collection Date: _____ Date Result Received: _____

TB Result Value: ☐ Positive ☐ Negative

This information must be legible and include professional credentials:

Administered/Collected by: _____
(Signature)

Place Physician's Office Stamp in the Box on the Right for Validation*:
*An Official Letter from the Physician/Nurse Practitioner detailing the above or **results from your electronic medical record information system** may be substituted for a validation stamp.

SEASONAL INFLUENZA VACCINATION (FLU SHOT)

Flu Season begins Mid- September through April 30th. Vaccinations should be administered within this time period each year.

Date Administered: _____ Site of Injection:

Lot # _____
Exp. Date _____

☐ Left Deltoid ☐ Right Deltoid

Administered by _____
(Signature)

_____ _____
(Please Print Name & Professional Credentials) (Office Address City, State Zip Code)

Place Physician's Office Stamp in the Box on the Right for Validation*:
*An Official Letter from the Physician/Nurse Practitioner detailing the above or **results from your electronic medical record information system** may be substituted for a validation stamp.

Additional Clinical Agency Requirements:

1. Proof of a clean background check. *Third party background checks are not accepted.*
2. Current CPR Certification—Basic Life Support for Health Care Provider.

Fingerprinting and Background Check - BOTH a Civilian (BCI) Check & Federal (FBI) Check Results are required.

- It is in your best interest to complete your background check screening in the School of Nursing Main Office as **early** as possible. **It can take as many as 30 days for the results to return to School of Nursing.**

Fingerprinting Locations

On CSU Campus – School of Nursing Main Office, Julka Hall, Room 238, (216) 687-3598
No appointment is necessary, however, we would like to know that you are coming to campus. Bring your Proof of Payment, Driver's License/State ID, and Request for Background Check Form (page 8).
The Combined cost of BCI & FBI Screenings is $60.00.

Monday – Friday
9:00 am – 4:00 pm

Ways to Pay:

- **Credit/Debit Card ~ ShopNet:**
  https://campusnet.csuohio.edu/ShopNet/index.jsp?owner=SONBGRNDCHK&skip=true
- **Cash/Check Payment**s: Bring this page to the Office of Treasury Services in Main Classroom, 1899 East 22nd Street, room 115 and pay the $60 fee. Your payment must be applied to the following:

ACCOUNT #: 0060-0010-0727-01-LAB_FEES

Off Campus

- **In-State** – Identify fingerprint locations on National WebCheck
  www.OhioAttorneyGeneral.gov/WebCheck or call 1-800-282-0515
- **Out-Of-State** - Contact your state's Bureau of Criminal Investigation & Information to request a Civilian Background check for your resident state.

If you are fingerprinted at an agency other than the School of Nursing, DO NOT use the form on page 8. You will be responsible for providing the agency with the EXACT responses as listed below. Results not received within 30 days are your responsibility to check the status of your fingerprint processing application.

Q: Reason for background check: (Be Specific)	Q: Address for results to be mailed to:
A: Student Entering Nursing School	A: CSU School of Nursing 2121 Euclid Avenue, JH 238, Cleve, OH 44115

This form is to be used for fingerprinting at the CSU School of Nursing Main Office ONLY:

Request for a Background Check via Electronic Fingerprinting

(X) Graduate () Undergraduate () Faculty (X) BCI and FBI

Personal Information (please print)

Name_____ State/Province_____

Date of Birth_____ SSN_____ Zip/Postal Code _____

Address_____ Phone#_____

City_____ Driver License Exp. Date: _____

This portion only is needed for FBI background check:

Gender ☐ Race ☐ Height ☐ Weight ☐ Hair ☐ Eyes ☐

Reason for background check (4723.09):

(X) New Admit Nursing Student
- ☐ Graduating Nursing Senior
- ☐ Faculty
- ☐ Other: **if checked must complete a different form**

Address for results to be mailed to:

___ CSU School of Nursing
___ Other: **if checked must complete a different form**

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*I certify that the personal identifiers provided on this form are accurate and I voluntarily and knowingly authorize the Ohio Bureau of Criminal Identification & Investigation to conduct a criminal records check for the information relating to me. I also voluntarily and knowingly authorize BCI&I to disseminate criminal arrest, conviction and juvenile delinquency adjudication records to **Cleveland State University**. 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:*** _____

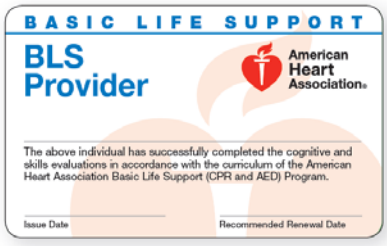
Administrator Initials: _____

Date prints taken: _____

Date prints received: _____

Cardiopulmonary Resuscitation

All students are required to maintain CPR certification – Basic Life Support (BLS) for the ***Healthcare Provider***. You may complete the course through any provider authorized by the **American Heart Association.** ***No other certification is acceptable.*** Two sources are listed below for your convenience:



- You must submit documentation of current CPR certification.

- **If you have already completed the correct course within the past twelve months, please provide documentation.**

- Your CPR certification for Healthcare Provider MUST BE renewed every **twenty-four (24) months throughout the program**. A copy (front & back) of your two-year re-certification must be submitted via US Mail to the School of Nursing upon completion of the course.

CPR Course Locations

On CSU Campus – Sigma Theta Tau, International
Nu Delta Chapter

- www.csuohio.edu/nursing/progandhealth.html
- (216) 875-9874

Off Campus (Ohio) – CPR Ohio

- Register online or by phone:
  - www.cprohio.com
  - (216) 251-0747
- East: Landerwood Plaza North, 30539 Pinetree, Suite 225, Pepper Pike, OH 44124
- West: Emerald Crossing, 4760 Grayton Road, Suite 3, Cleveland, OH 44135

Off Campus (Outside Ohio)

- Contact any local provider authorized by the American Heart Association.

Clinical Practicum Agency Onboarding Requirements:

Students are responsible for completing all clinical practicum agency onboarding requirements prior to the start of any clinical practicum experience**.**