



# PROGRAM AND HEALTH REQUIREMENTS

## FOR

# RN to BSN STUDENTS

Cleveland State University



School of Nursing

*Advancing Excellence in Nursing Professionals*

## PROGRAM AND HEALTH REQUIREMENTS FOR RN TO BSN STUDENTS

This packet contains information and forms which must be completed. Please adhere to the deadline for submission of the forms to the School of Nursing:

- By the end of the 1<sup>st</sup> Semester of Enrollment

- **RN to BSN Program Student Handbook:**

- Go to the School of Nursing Home page at:  
[https://www.csuohio.edu/nursing/sites/csuoio.edu.nursing/files/UPDATED%20RN-BSN%20Program%20Student%20Handbook%202018\\_2019.pdf](https://www.csuohio.edu/nursing/sites/csuoio.edu.nursing/files/UPDATED%20RN-BSN%20Program%20Student%20Handbook%202018_2019.pdf)
- Download the RN to BSN Program Student Handbook and read completely
  - Print and sign the following sheets:
    - ✓ Memorandum of Understanding
    - ✓ Informed Consent

- **Program and Health Documentation Required:**

- Health Examination Medical Forms with TDap Booster
- Ability to Perform Nursing Tasks Form
- Hepatitis B Titer Results
- Measles Mumps Rubella (MMR) Titer Results
- Varicella (Chicken Pox) Titer Results
- Tuberculin Mantoux Skin Test or Chest X-Ray Verification
- Seasonal Influenza Vaccination

- **Other Information Required:**

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

### Ways to Submit Your Documents:

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

~ OR ~

- **Fax:** CSU School of Nursing  
Attn: Health Data Records  
(216) 687-3556

## 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 this page and give to your physician/nurse practitioner when the physical examination is done. **This information will be treated confidentially.**

Last	First	M. I.	CSU I.D. Number
Street Address:			
(City)			(State)
( )	( )	____/____/____	
(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.)*

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

Do you use tobacco in any form? If yes, specify type: \_\_\_\_\_ Amount: \_\_\_\_\_

Do you have any physical impairment that limits your activity?       No     Yes (If yes, please explain)

Do you have any other health or medical problems not listed?       No     Yes (If yes, please explain)

Are you presently taking any kind of medication(s)  No     Yes (If yes, name drug(s) and how often taken)

Do you have any allergies (food, medicine, environmental)?     No     Yes (If yes, please list)

*I hereby certify that I have read and understand all of 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

## Ability to Perform Nursing Tasks

Please consider carefully any physical limitations you might have. If you have a diagnosed disability that may prevent you from carrying out any of these physical expectations, please discuss your situation with the School of Nursing Undergraduate Program Director/Advisor. Students who enter the program do so with the understanding that they will be expected to meet course requirements, with or without any reasonable accommodations. Students who have a disability will be referred to the Office of Disability Services for determination of the reasonable accommodation that can be made.\* Inability to carry out any of these activities while in the program may prevent completion of the program.

### **Students – Please place a checkmark next to the items that you are unable to perform.**

- \_\_\_\_ 1. Work for hours in a standing position and do frequent walking and stair climbing.
- \_\_\_\_ 2. Independently lift and transfer an adult patient up to 6 inches from a stooped position; then, push or pull the adult up to 3 feet.
- \_\_\_\_ 3. Independently lift and transfer an adult patient while you move from a stooped to an upright position to accomplish bed-to-chair and chair-to-bed transfers.
- \_\_\_\_ 4. Physically apply up to 10 pounds of pressure to bleeding sites or in performing CPR.
- \_\_\_\_ 5. Immediately respond and react to auditory instructions/requests, monitor equipment and perform auditory auscultation without auditory impediment.
- \_\_\_\_ 6. Perform a clinical/laboratory experience for up to 12-hour duration, including standing for up to 4 hours straight at a time.
- \_\_\_\_ 7. Perform close and distant visual activities involving objects, persons, and paperwork, as well as discriminate depth and color perception (If need accommodation, i.e. glasses or contacts, check line).
- \_\_\_\_ 8. Discriminate between rough/smooth and hot/cold when using hands.
- \_\_\_\_ 9. Manipulate small objects in precise movements; for example, prepare and administer injectable medications.
- \_\_\_\_ 10. Communicate intelligibly, both orally and in writing.
- \_\_\_\_ 11. Use products containing natural rubber latex due to allergy.

### **STUDENT STATEMENT – PLEASE SIGN ONE OF THE FOLLOWING STATEMENTS:**

1. I am able to perform the unchecked tasks **without** accommodation.

Student Signature \_\_\_\_\_ Date \_\_\_\_\_

2. I am able to perform the checked tasks only **with** accommodation.

Student Signature \_\_\_\_\_ Date \_\_\_\_\_

**If you have a disability that requires accommodation, please have your physician/nurse practitioner verify the disability.**

### **PHYSICIAN STATEMENT**

I have examined the above student and hereby verify that she or he has a physical disability (# \_\_\_\_\_ above) that will require accommodations in order to carry out activities.

Physician/Nurse Practitioner Signature \_\_\_\_\_

Physician/Nurse Practitioner Name \_\_\_\_\_ Date \_\_\_\_\_

(Please print name) **This information must be legible and include professional credentials.**

\* The University Office of Disability Services will determine if an accommodation is reasonable in accordance with applicable law.

To be completed by a physician/nurse practitioner. Please return to:  
School of Nursing, Attn: Health Data Records  
2121 Euclid Avenue, JH 238  
Cleveland, OH 44115-2214

CLEVELAND STATE UNIVERSITY ♦ SCHOOL OF NURSING ♦ RNtoBSN PROGRAM

Student Name: \_\_\_\_\_ CSU I.D. Number: \_\_\_\_\_ Date: \_\_\_\_\_

PHYSICAL EXAMINATION	*ABNORMAL	HEIGHT	WEIGHT	PULSE	B/P
General Appearance					
<b>PHYSICIAN'S NOTE ON PHYSICAL &amp; SUMMARY OF SIGNIFICANT FINDINGS*Abnormal finds must have documentation.</b>					
Skin					
Eyes, include Fundus					
Ears /Hearing					
Nose/Sinuses					
Mouth, Throat					
Neck, include Thyroid					
Chest, include Breasts					
Heart					
Vascular System					
Lymphatic System					
Abdomen, Include Inguinal					
Genitourinary System					
Nervous System					
Extremities					
Spine, Other Musculoskeletal					
Anus, Rectum					
<b>DISTANT VISION</b>				<b>URINE</b>	<b>HEARING</b>
Right 20/___    Corrected to 20/___ Left 20/___    Corrected to 20/___ Both 20/___    Corrected to 20/___			<input type="checkbox"/> Glucose <input type="checkbox"/> Protein	Right: <input type="checkbox"/> Passed    Left: <input type="checkbox"/> Passed <input type="checkbox"/> Failed <input type="checkbox"/> Failed	

**IMMUNIZATIONS/INFECTIOUS DISEASE EVALUATION – REQUIRED. Titer test results from your electronic medical record information system are also acceptable in lieu of a validation stamp for the pages listed below:**

Tetanus/Diphtheria – Boosters required every 10 years.    Date of Last Booster: \_\_\_\_\_

Hepatitis B Titer ..... **Complete Form on Page 7**

MMR Titer (Measles-Rubeola), Mumps, Rubella) ..... **Complete Form on Page 8**

Varicella Titer ..... **Complete Form on Page 9**

Tuberculin (TB) Skin Test or QuantiFeron Results ..... **Complete Form on Page 10** NOTE: Chest x-ray required results are positive (CHEST X-RAY: Date & Results)

Seasonal Flu – Required ..... By October 15<sup>th</sup>, **Complete Form on Page 11**

\_\_\_\_\_  
**Physician/Nurse Practitioner's Name (Please Print)**                      **Office Address**                      **City, State**                      **Zip Code**  
 This information must be legible and include professional credentials.

\_\_\_\_\_  
**Examining Physician or Nurse Practitioner Signature**                      **Date**                      **Phone # including area 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 may be substituted for a validation stamp.

**IMMUNIZATION STATUS** – Students must provide documentation of satisfactory immunization status for the following:

- a. Tetanus-Diphtheria Toxoid - Most students will have completed their original DPT (Diphtheria, Pertussis or "Whooping Cough" and Tetanus) series during their childhood. If the student was older than six years, the primary immunization series required three injections of TD. The date of completion of either series and the date of a TD (Tetanus-Diphtheria) booster within the past ten years must be recorded on the **Health Examination Form** Please indicate number of immunizations received in the series and dates of the boosters. 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.
- b. 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
- c. 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 result recorded on the **Verification of Having Varicella (Chicken Pox) Illness, Immunization, and Blood Titer Test Form**.
- d. TB Test - The two-step TB Mantoux Test or QuantiFERON report is required for all students admitted to the Nursing Program and a one-step or QuantiFERON is required for every subsequent year in the program. 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 Cleveland MetroHealth Medical Center. The telephone number is (216) 778 - 8305. An appointment is required. The PPD is also available at the CSU Health & Wellness Services Department.
- e. Hepatitis B – The School of Nursing requires that all nursing students receive the Hepatitis B Vaccine. This is to be administered as a series of three. The date of each dose is to be recorded on the **Verification of Completed Hepatitis B Immunization Form** and submitted after each injection. Documentation of a positive titer is required to show immunity. The vaccine is also available at the CSU Health & Wellness Services Department.
- f. 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 15<sup>th</sup> ANNUALLY to be qualified to continue or begin clinical. **\*\*In the case of an allergic reaction to the flu vaccine, an official from the physician must be submitted annually, listing the diagnosis and the physician’s contact information.**

To be completed by physician or nurse. Please return to:  
 School of Nursing, Attn: Health Data Records  
 2121 Euclid Avenue, JH 238  
 Cleveland, OH 44115-2214

## HEPATITIS B IMMUNIZATION

Student Name: \_\_\_\_\_ CSU ID Number: \_\_\_\_\_

Have you completed a series of Hepatitis B immunization?

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

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

**If your results are positive, you are done!**

2. If not, one full series of re-immunization is required followed by a second titer to confirm immunization.

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

3. Upon completion of the full series, a second titer to confirm immunization is required.

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

4. 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.

\* \* \*

**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, or **results from your electronic medical record information system** may be substituted for a validation stamp.

To be completed by physician or nurse. Please return to:  
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 Cleveland, OH 44115-2214

## MEASLES MUMPS RUBELLA (MMR) IMMUNIZATION

Student Name: \_\_\_\_\_ CSU ID Number: \_\_\_\_\_

Have you received your MMR immunization?

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

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

**If your results are positive, you are 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 re-immunization, a **second titer** to confirm immunization is required:

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

4. 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.

\*\*\*\*\*

**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, or **results from your electronic medical record information system** may be substituted for a validation stamp.



To be completed by physician or nurse. Please return to:  
 School of Nursing, Attn: Health Data Records  
 2121 Euclid Avenue, JH 238  
 Cleveland, OH 44115-2214

## VARICELLA (CHICKEN POX) IMMUNIZATION

Student Name: \_\_\_\_\_ CSU ID Number: \_\_\_\_\_

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

**If your result is positive, you are 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>		Place Physician's Stamp in this Box for Validation*
Physician/Nurse Practitioner Name & Credentials (Please Print):		
(Date of Varicella Booster)	(Physician/Nurse Practitioner Signature)	

3. Upon completion of the full series, a second titer to confirm immunization is required.

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

4. 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.

\* \* \*

**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, or **results from your electronic medical record information system** may be substituted for a validation stamp.

To be completed by a physician/nurse practitioner after the test has been read. Please return to:  
 School of Nursing, Attn: Health Data Records  
 2121 Euclid Avenue, JH 238  
 Cleveland, OH 44115-2214

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

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

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

**MANTOUX**

**STEP ONE: To be performed annually**

**STEP TWO: To be performed 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

**QUANTIFERON**

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

Results:  Positive  Negative

---

Physician ' s/Nurse Practitioner's Name (Please Print) <b>This information must be legible and include professional credentials.</b>	Office Address	City, State	Zip Code
---	----------------	-------------	----------

\_\_\_\_\_  
Physician/Nurse Signature

\_\_\_\_\_  
Date

The Quantiferon or two-step TB Mantoux Test report is required for all students admitted to the Nursing Program. The Quantiferon 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.**

**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.



To be completed by a physician/nurse practitioner. Please return to:  
School of Nursing  
2121 Euclid Avenue, JH 238  
Cleveland, OH 44115-2214

**SEASONAL INFLUENZA (FLU SHOT) VACCINATION**

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

FLU SEASON TYPICALLY BEGINS MID SEPTEMBER.

VACCINATIONS ARE NOT AVAILABLE BEFORE THIS TIME.

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

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

**Please provide the following:**

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

Lot # \_\_\_\_\_ Exp. Date \_\_\_\_\_

Site of Injection:  Left Deltoid  Right Deltoid

Administered by \_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Please Print Name)

\_\_\_\_\_  
Office Address: City, State Zip Code

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

**This information must be legible and include professional credentials**

\*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.

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

\*\*In the case of an allergic reaction to the flu vaccine, an official from the physician must be submitted annually listing the diagnosis and the physician's contact information

## 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:

<http://www.csuohio.edu/offices/health/HealthInsurance.html>

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

Student’s Name <small>(Last, First, M.I.)</small>	CSU I.D. Number

Policy Holder’s Name (if different from Student): \_\_\_\_\_

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

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

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

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

**Other Requirements:**

1. Proof of a clean **Background Check**. If you have been fingerprinted within the past 12 months (i.e. NCLEX, hospital employment), please provide an official copy of the results. **The acceptable code for the School of Nursing is 4723 09.** *Third party background checks are not accepted.*
2. Current **CPR Certification**—Basic Life Support for Health Care Provider. *On-line courses are not accepted.*

**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 17).**  
**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 Payments:** Bring this page to the Office of Treasury Services in Main Classroom, 1899 East 22<sup>nd</sup> 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](http://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 printed at an agency other than the School of Nursing, DO NOT use page 14. 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.***

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, Health Data Records 2121 Euclid Avenue, JH 238 Cleveland, OH 44115

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

**Request for a Background Check via Electronic Fingerprinting**

( ) Graduate    (X) 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):**

- 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
- \_\_\_\_\_ Ohio Board of Nursing
- \_\_\_\_\_ Other: **if checked must complete a different form**

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

**Method of Payment:**

~ShopNet without Receipt, Reference # \_\_\_\_\_

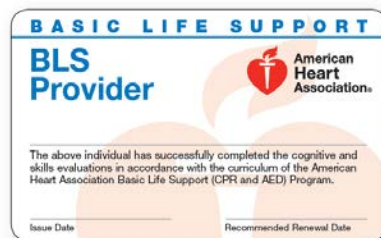
~Cashiers Office, Receipt Attached \_\_\_\_\_

**Administrators Initials:** \_\_\_\_\_

**Date Results 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 (24 months from the date of certification it must be renewed).**
- Your CPR certification for Healthcare Provider **MUST BE renewed every twenty four (24) months throughout the program**. A copy of your two-year re-certification card must be submitted upon completion of the course **biennially**.

### CPR Course Locations

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

- [www.csuohio.edu/nursing/progandhealth.html](http://www.csuohio.edu/nursing/progandhealth.html)
- (216) 875-9874

**Off Campus (Ohio)** – CPR Ohio

- Register online or by phone:
  - [www.cprohio.com](http://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 your local **American Heart Association**.