

**MOLLOY UNIVERSITY**  
**THE BARBARA H. HAGAN SCHOOL OF NURSING & HEALTH SERVICES**  
**REQUIREMENTS**  
**FOR ATTENDING CLINICAL PRACTICE**

Each item must be completed:

1. Physical examination using the **Barbara H. Hagan School of Nursing and Health Sciences FORM**. FORM MUST BE SIGNED, STAMPED AND DATED BY PROVIDER AND INCLUDE:
  - On initial physical for Advanced Physical Assessment NUR 5721, 2, 3, 4, and all subsequent clinical rotations, you must provide documentation of *two* PPDs implanted within 365 days of each other, a Quantiferon blood test, OR a T-Spot PPD
  - Each subsequent physical requires only *one* PPD or Quantiferon blood test or T-Spot PPD
  - Laboratory Titer Reports (LAB SHEETS) for Rubella, Rubeola, Varicella, Mumps Numerical Values for each are required
  - Physicals/PPD must be submitted annually to CastleBranch at [www.castlebranch.com](http://www.castlebranch.com)  
**Questions regarding uploading documents? CONTACT 1.888.723.4263**
    - Summer Semester:** uploaded to CastleBranch on or before April 15<sup>th</sup>
    - Fall Semester:** uploaded to CastleBranch on or before July 15<sup>th</sup>
    - Spring Semester:** uploaded to CastleBranch on or before December 1<sup>st</sup>
2. CPR-Cardio pulmonary resuscitation certification must be completed. **No online course will be accepted.** CPR cards must be submitted (Make copy of front and back) with your Physical Information. Acceptable courses provided by: **American Heart Assoc. – BLS for Health Care Providers**  
**American Red Cross – BLS for the Professional Rescuer**
3. Uniform for Clinical Experience: Students are to wear plain white lab coats (no affiliation badges of any kind are to be displayed on the lab coat). The Molloy University photo ID Badge is to be worn and clearly visible.
4. Clinical Agency Affiliation Requirements: Individual clinical agency affiliates may require additional medical tests and/or clearance requirement for students entering their agencies. Student will be notified of any additional requirement AFTER the clinical placement contract is completed and signed by the agency.
5. Students must submit a copy of NYS RN license registration certificate.
6. Late Fee: A fee of \$50.00 is charged to process physical documents submitted after submission due date.
7. Review the Molloy University Nursing Handbook and review policies and health requirements.
8. Sign HIPAA and Latex forms.
9. FLU vaccines are valid for the influenza season (generally August to June of following year).
10. Malpractice Insurance appropriate to your program (Registered Nurse or Nurse Practitioner Addend to: **NP STUDENT**) with coverage of \$1,000,000 per claim/\$3,000,000 aggregate.
11. Evidence of OSHA training (NYS Infection Control Certificate) CMEResource.com will bring you to NetCe website. Follow the prompts to #9864 Infection Control: The NYS Requirement
12. Students are expected to carry their own health insurance.

# **Attention All Graduate Nursing Students**

**For clarification of all forms**

**Contact:**

**Mary Jane O'Malley**

**[momalley@molloy.edu](mailto:momalley@molloy.edu)**

**Students should make photo copies of all submitted documents. We are not permitted to make copies for your use!**

**MOLLOY UNIVERSITY**  
**THE BARBARA H. HAGAN SCHOOL OF NURSING & HEALTH SERVICES**  
**PHYSICAL FORM**

Molloy University – Barbara H. Hagan School of Nursing & Health Sciences  
Mary Jane O'Malley [momalley@molloy.edu](mailto:momalley@molloy.edu)  
1000 Hempstead Ave., Rockville Centre, New York 11571-5002

*Anticipated Class  
next semester:*

\_\_\_\_\_  
*Course      Section*

*Last Name* \_\_\_\_\_ *First Name* \_\_\_\_\_ *ID#* \_\_\_\_\_  
*Maiden Name* \_\_\_\_\_ *Date of Birth* \_\_\_\_\_  
*Address* \_\_\_\_\_ *Gender* \_\_\_\_\_  
\_\_\_\_\_ *Phone* \_\_\_\_\_

**Required on Initial Physical Only: TITERS NEED TO BE DONE ONE TIME ONLY**  
**LAB REPORTS MUST BE ATTACHED FOR EACH TITER!**

Rubella Titer    Value: \_\_\_\_\_ Result: \_\_\_\_\_ Date: \_\_\_\_\_  
Rubeola Titer    Value: \_\_\_\_\_ Result: \_\_\_\_\_ Date: \_\_\_\_\_  
Varicella Titer    Value: \_\_\_\_\_ Result: \_\_\_\_\_ Date: \_\_\_\_\_  
Mumps Titer      Value: \_\_\_\_\_ Result: \_\_\_\_\_ Date: \_\_\_\_\_

**HISTORY OF VACCINATIONS:** Please provide immunization dates if *Titers are Equivocal or Negative*

MMR #1 \_\_\_\_\_ MMR #2 \_\_\_\_\_ VARICELLA #1 \_\_\_\_\_ VARICELLA #2 \_\_\_\_\_  
Hepatitis B Vaccine:    HepB #1 \_\_\_\_\_ HepB #2 \_\_\_\_\_ HepB #3 \_\_\_\_\_

**NURSING STUDENTS ARE TO BE IMMUNIZED WITH HEPATITIS B VACCINE PRIOR TO THE BEGINNING  
OF CLINICAL PRACTICE OR MUST SIGN A DECLINATION STATEMENT.**

**DECLINATION STATEMENT**

*If HepB titer is Negative or Equivocal and you DO NOT have record of your immunization you must sign Declination.*

I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B virus (HBV) infection. I have been informed of the need to be vaccinated with Hepatitis B Vaccine. However, I decline Hepatitis B vaccination at this time. I understand that by declining this vaccination, I continue to be at risk of acquiring Hepatitis B, a serious disease.

Name (Print): \_\_\_\_\_

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

**Diphtheria/TetanusPertussis: [Within Last 10 Years] (Tdap)\_\_\_\_\_ (Td)\_\_\_\_\_**

If, as an adult you haven't had a vaccine that contains pertussis (whooping cough) one of the doses you receive needs to have pertussis in it.

I certify that \_\_\_\_\_

Is in good health as determined by a recent physical examination of sufficient scope to ensure that the student is free from health impairments which may be of potential risk to patients or other personnel or which may interfere with the performance of the student's duties, including habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances which may alter individual behavior. This individual is able to participate in clinical learning experiences as a student of Nursing.

I have identified the following:

B.P.: \_\_\_\_\_

Vision: \_\_\_\_\_ Hearing: \_\_\_\_\_

Allergy to Latex: Yes: \_\_\_\_\_ No: \_\_\_\_\_ Other Allergies: \_\_\_\_\_

Illnesses: \_\_\_\_\_

Injuries: \_\_\_\_\_

Restrictions on activity: \_\_\_\_\_

Medications: \_\_\_\_\_

Disabilities: \_\_\_\_\_

**\*\*Students with disabilities are considered on an individual basis. Students must be able to meet program objectives.**

Name of Health Care Provider:

\_\_\_\_\_  
**(Stamp Is Required)**

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

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

**HEALTH CARE PROVIDER**

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

**MOLLOY UNIVERSITY**  
**THE BARBARA H. HAGAN SCHOOL OF NURSING & HEALTH SCIENCES**  
**PPD FORM**

Molloy University – Barbara H. Hagan School of Nursing & Health Sciences  
Mary Jane O'Malley [momalley@molloy.edu](mailto:momalley@molloy.edu)  
1000 Hempstead Ave., Rockville Centre, New York 11571-5002

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ ID# \_\_\_\_\_  
Maiden Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Address \_\_\_\_\_ Gender \_\_\_\_\_  
\_\_\_\_\_ Phone \_\_\_\_\_

- **ONE OF THE FOLLOWING MUST BE COMPLETED WITHIN THE PAST 12 MONTHS. If positive results, submit physician clearance on letterhead. A TWO STEP PPD is required for first time clinical students only.**

1. PPD – Tuberculin Test (PPD intradermal only) [MUST BE READ 48 – 72 HOURS LATER]

Date Implanted: \_\_\_\_\_ Date Read: \_\_\_\_\_ Result: \_\_\_\_\_

**\*2nd PPD IS REQUIRED AND SHOULD BE IMPLANTED WITHIN 364 DAYS OF THE 1st PPD\***

Date Implanted: \_\_\_\_\_ Date Read: \_\_\_\_\_ Result: \_\_\_\_\_

**OR**

2. QuantiFERON TB Gold Result: \_\_\_\_\_ Date: \_\_\_\_\_ Lab Sheet Must Be Attached

**OR**

3. T-Spot Result: \_\_\_\_\_ Date: \_\_\_\_\_ Lab Sheet Must Be Attached

- POSITIVE FINDINGS OF ALL TUBERCULOSIS TESTS REQUIRE A NEGATIVE CHEST XRAY REPORT. XRAY REPORT MUST BE ATTACHED:

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

Name of Health Care Provider: \_\_\_\_\_

\_\_\_\_\_  
Address Phone Number

**\*STAMP IS REQUIRED\***

**MOLLOY UNIVERSITY**  
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**Latex Allergy Policy**

**Background:** Latex allergy has become a serious healthcare problem. Experts have described it as a disabling occupational disease among healthcare workers (American Nurses Association, 1997).

The allergic reaction to latex is evoked by direct contact with products containing latex rubber or by inhaling powder from latex gloves. Responses may range in severity from a rash to asthma attacks to death from anaphylaxis (New York State Nurses Association, 1999).

The increased need to don gloves in both medical and non-medical settings has increased the prevalence of latex allergies. A 1997 alert published by the National Institute of Occupational Safety (NIOSH) indicated that less than 1% of the general population and 8% to 17% of regularly exposed healthcare workers are sensitized to latex (American Latex Allergy Assoc., 2016). These statistics indicate that an increasing number of entering nursing students may already have a latex sensitivity. Beginning one's professional life with a latex allergy presents unique challenges for students and faculty.

In light of this growing problem the School of Nursing has developed the following policy related to latex exposure.

**Initial Steps:** All Molloy School of Nursing Student and Faculty History and Physical Forms to have a category, which indicates *Latex Allergy*. The healthcare provider completing the form must specifically respond to this item.

**Follow-Up:** In those instances where a latex allergy has been indicated, faculty/student will need to be contacted by Health Services: The following actions should be initiated:

- Faculty/Student will be given literature on latex allergies
- Faculty/Student will be counseled regarding acceleration of sensitivity with repeated exposures
- Faculty/Student will be encouraged to wear a Medi-Alert bracelet as suggested by NIOSH
- Faculty/Student acknowledgement of this policy will be kept on file in department

**Agency Contact:** The faculty/student will be responsible for sharing information about themselves regarding latex allergy with the respective clinical agency.

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I am a faculty member/student in the Molloy University School of Nursing. I have read the Molloy University policy concerning Latex Allergy.

I do not have any allergy to latex, or

I have a latex allergy and I have previously so notified Molloy University. I am fully aware of the dangers arising out of exposure to latex and I agree to exercise appropriate caution. I hereby release Molloy University, its Board of Trustees, officers and administrators and employees from any claim or liability arising out of my exposure to latex either on the campus of Molloy University or in any clinical setting.

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

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**MOLLOY UNIVERSITY**  
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**Health Insurance Portability and Accountability Acknowledgment Form**

Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal Amendment to the Internal Revenue Code of 1986 concerning health insurance and issues in combating fraud and abuse in health insurance and health care delivery.

- HIPAA provides for standardization of the interchange of medical data
- Protects patient privacy
- Protects security of patient data

FERPA stands for Family Educational Rights and Privacy Act (Buckley Amendment). Passed by Congress in 1974 the Act grants four specific Rights to the student.

The right to see the information the institution is keeping on the student

The right to seek amendment to those records and in certain cases append a statement to the record

The right to consent to disclosure of his/her records

The right to file a complaint with the FERPA office in Washington

Confidentiality provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as well as provisions of the Family Educational and Privacy Act of 1974 (FERPA) have been explained to me and I fully understand them.

I hereby authorize release of information from my student health record to affiliated clinical agencies as indicated below in accordance with all relevant State and Federal confidentiality laws including the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the Federal Educational Rights and Privacy Act of 1974 (FERPA).

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

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**MOLLOY UNIVERSITY**  
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**FLU VACCINE FORM**  
**DUE BETWEEN OCTOBER 1<sup>st</sup> – DECEMBER 1<sup>ST</sup>**  
**PLEASE PRINT**

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*Student Name*

*Molloy ID Number*

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*E-Mail Address*

*Phone Number*

*Course & Section*

**Entire form must be completed**

*Manufacturer or Company Name of Vaccine*

\_\_\_\_\_

*Lot Number of the Vaccine*

\_\_\_\_\_

*Expiration Date*

\_\_\_\_\_

*Dose Administered*

\_\_\_\_\_

*Date Administered*

\_\_\_\_\_

*Placement*

*Right Deltoid*

*Left Deltoid*

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*Name of Provider*

*License Number*

*Stamp*

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*Address of Provider*