NRSG 1710 (1st Semester) - Fundamentals
NEW STUDENT INFORMATION SHEET – Questions? Call 423-585-6870

Please read carefully (9 pages) All required documents must be submitted by the deadlines indicated below.

MANDATORY NURSING ORIENTATION AUGUST 1, 2019 at 8:00 a,m. TECH 150 MORRISTOWN		
	Complete all steps.	**DEADLINES**
Step 1	**Physical Form** (Cream Sheet) - – Make your appointment date as soon as possible. ***Dates are important*** – Check the boxes when completed! Be SURE your Health Care Provider has documented in ***all*** the spaces. ☐ Complete Physical form on both sides (cream sheet) side 1 completed by student, side 2 completed by Health Care Provider ☐ 2-Step TB Skin Test with placement dates, reading dates, and results. First test is placed, read within 48-72 hours. Student returns 1-3 weeks later for second placement. Second test is placed, read 48-72 hours later. After the initial 2-step TB skin test, students will complete an annual 1-step test. Chest x-ray required if TB skin test is positive. ☐ Tetanus (TDAP) with date (must have been received within previous 10 years) ☐ (2) MMRs with date or rubella AND rubeola AND mumps titers that indicate immunity ☐ (3) Hepatitis B vaccine dates or Hepatitis B titer that indicates immunity ☐ (2)Varicella vaccine dates or Varicella titer that indicates immunity ☐ current season flu shot (student will submit flu shot annually as seasonal flu shot becomes available) *If titers are drawn to show immunity, **titer report lising results and immunity reference ranges** must be submitted with the physical form. Contraindications for MMR, Hep B, or Varicella must be documented by Healthcare Provider***** *****STUDENT MUST TURN IN ORIGINAL CREAM COLORED PHYSICAL FORM FROM THE HEALTH PROGRAMS OFFICE. NO COPIES OR UNOFFICIAL FORMS WILL BE ACCEPTED. PHYSICALS WILL BE CURRENT FOR 2 CALENDAR YEARS FROM THE DATE OF ADMINISTRATION BY THE HEALTH CARE PROVIDER AS LONG AS THE STUDENT MAINTAINS CONTINUOUS ENROLLMENT.**	**Student makes her/his appt.** **Health Care Provider must complete physical form.** **Submit August 26** ****If you did not complete one for Spring 2019**
Step 2	**2019-2020 Seasonal Flu Shot:** Students must receive the flu vaccine annually when it becomes available. Students must submit documentation with packet.	**Submit October 1 or soon as received.**
Step 3	**Insurance Forms:** Go to: **WWW.NSO.COM** (1-800-247-1500) – See instructions on page 2 of this packet. (If you are licensed or credentialed in more than one healthcare profession such as CNA, LPN, EMT, etc., and therefore need to apply for dual coverage, prices will vary & you must call 1-800-247-1500 to order.)	**Proof of coverage and payment due August 26**
Step 4	**CPR:** Submit copy of front/back of CPR Card. Completion card ***must*** be ***American Heart Association, BLS Provider.*** No other types of CPR will be accepted. Students may contact the American Heart Association or consult the American Heart Association website to locate AHA Health Care Provider BLS courses.	**Submit August 26**
Step 5	**Health Insurance Card:** Submit a copy of your current health insurance card. Due to clinical facility requirements, you must notify the health programs office should any health insurance coverage change during the program.	**Submit August 26**
Step 6	**Forms:** Please complete and/or sign: Health Insurance Consent Form, Consent Form, Student Conduct Form, HIPPA (Privacy agreement), Criminal Background form, and Drug/Alcohol Abuse Policy (a portion of this info is in your handbook that you are required to read) All consent forms are valid for 2 calendar years from date signed unless student is readmitted	**Submit August 26**
Step 7	**TNF Fee:** (TN Nurse's Foundation fees) **TNF fee is $5**. TNF receipt form is included in this packet. Take the form to the cashier's office to make payment. Make a copy of receipt, attach to receipt form and submit with your completed packet. ***Acceptable means of payment are credit card, debit card, cashier's check, money order or cash. Cashier's checks/money orders are payable to Walters State Community College.*** All fees are nonrefundable.	**Pay Cashier's Office by August 26 and submit receipt with packet.**
Step 8	**Evolve HESI Fee:** (Nursing Program Assessment Testing/Case Studies) – Further instructions at program orientation.	**TBA**
Step 9	**Criminal Background Check:** A Truescreen criminal background check is required for participation in most clinical experiences. Students will be required to submit a clear background check to requesting clinical facilities. **The cost will be approximately $31.25.** Instructions for ordering your background check will be provided at orientation.	**Order by August 26**
Step 10	**Drug Screen:** Most clinical agencies require drug screens. If you are required to complete a drug screen for your assigned clinical agency, you will be notified to do so prior to clinical orientation. ***Drug screens will be ordered through Truescreen. Chain of custody forms will be handed out the day of orientation along with instructions.***	**Order by August 26**
Step 11	**Photo:** One (1) photo of student **with signature on back**. Picture should be of the student only (no groups of people, please), no bigger than 3x5, and appropriate. Inappropriate pictures will not be accepted.	**Submit August 26**
Step 12	**MAKE A COPY OF ALL DOCUMENTATION BEFORE SUBMITTING!** Professional development implies that **YOU** maintain your personal records of the above. Documentation submitted will not be returned for any reason.	**Make copies for yourself**
Step 13	**IDs**: Photos for student clinical ID badges will be taken at the start of Nursing Orientation. Please dress appropriately.	
Step 14	**Do not turn in packets at the Health Programs window.** Packets will be collected at the start of class on August 26 in TECH 150 and GRN classroom.	**Packets will be collected.**

Criminal Background checks are a requirement for training at all affiliated clinical sites. Based on the results of these checks, an affiliated clinical site may determine to not allow your presence at a facility. Additionally, a criminal background may preclude licensure or employment. If you are assigned to a clinical affiliate requiring a criminal background check, you will be required to provide the requested information. Acceptance of you as a student in the clinical facility will be at the clinical affiliate's discretion. As a student, you will be responsible for the cost of any required background checks. If a clinical affiliate denies your presence in the facility, you will not be able to complete the clinical/practicum and you will be withdrawn from the program. The specifications for the background check are at the discretion of the clinical affiliate. Should the affiliate not require a specific vendor for the check, the program director will provide a list of available vendors to purchase the required criminal background check. The cost of the criminal background check will average $90.00. The exact amount may vary based on the affiliate specifications and individual student differences. As a student you will not be allowed access to a clinical facility for any student experience until the clinical facility has authorized your presence.

***** *Acceptance of you as a student in a clinical facility will be at the clinical affiliate's discretion. If a clinical affiliate denies your presence, you will not be able to complete the clinical\practicum and you will be withdrawn from the program*

To assist us in allowing others into the program, please notify us if your plans change. Call 423-585-6968.

NSO Liability Insurance Instructions

Go to www.nso.com (students with additional licenses must call 1-800-247-1500)

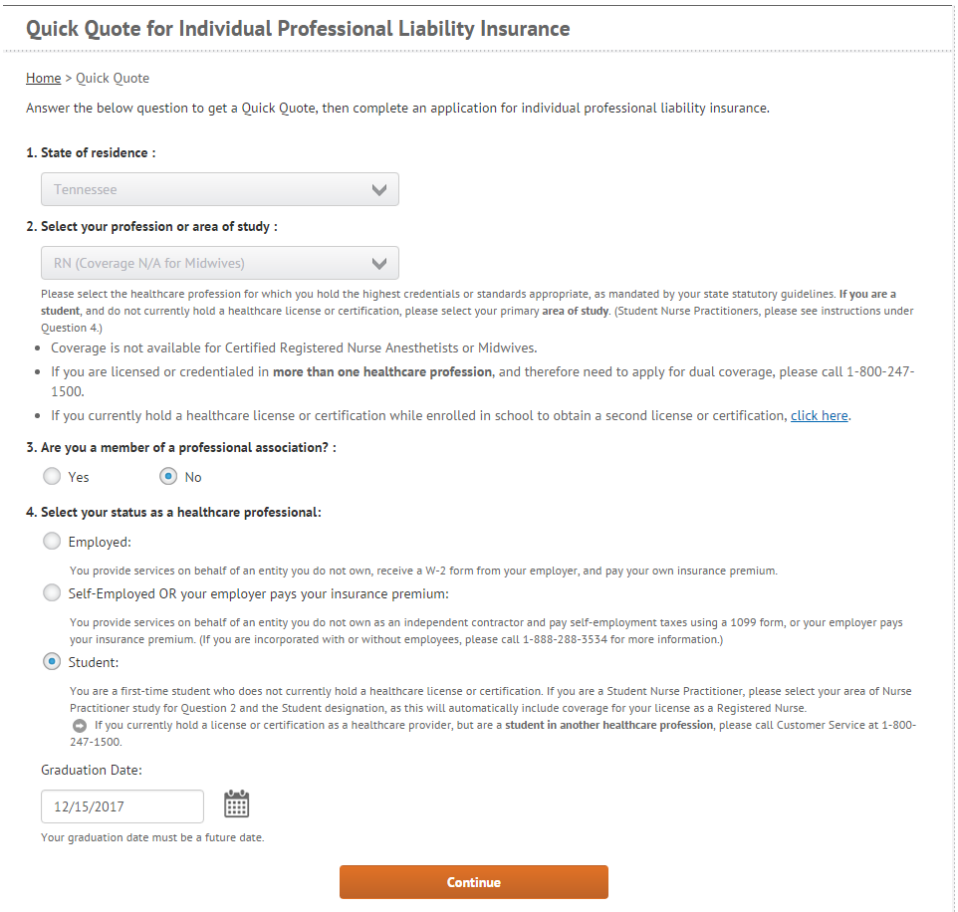
Select "**Individuals**" at the top left of the screen and select "Student Nurse." On the next screen, select "**Get a Professional Liability Insurance Quote," select "Individual" and click "continue"** to fill out the form. See screenshots below to complete your application.

Question Guidelines:
2. Students should select RN (Coverage N/A for Midwives) as profession/area of study.

3. Students are not members of professional organizations.

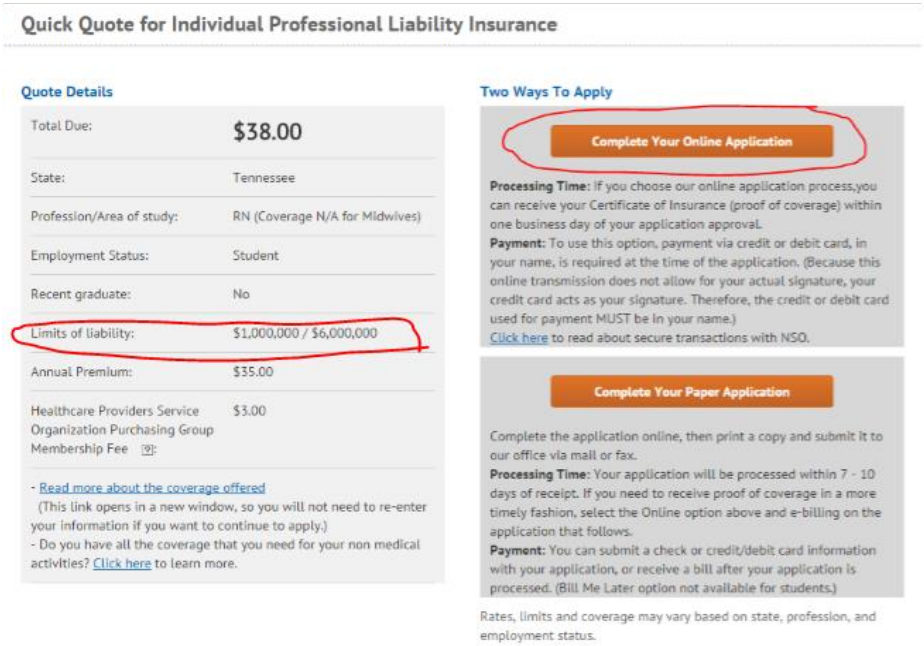
4. Status should be student

Graduation date is 5/8/2021.



Limits of liability should be 1 million – 6 million.

The minimum coverage requirement is 1 million – 3 million. Lower coverage amounts will not be accepted.



Certificate of insurance and proof of payment should be submitted with packet on August 26. Medical specialty on certificate should state registered nurse student. Students may also enter the Health Programs fax number while completing the online application to have certificate faxed directly to the office: 423-585-6955.

Name: _____

Semester: Fall 2019 Course: NRSG 1710

TNF Receipt Form

LPNs do not pay this fee.

1. Take this document to the Cashier's Office and pay TNF fee of $5.00.

2. Make a copy of your receipt. Keep the copy for yourself.

3. Attach the original receipt to this document.

4. Submit this document and original receipt with your packet.

Fee payment deadline: August 26, 2019.

WALTERS STATE COMMUNITY COLLEGE
DIVISION OF HEALTH PROGRAMS
HEALTH INSURANCE CONSENT FORM

I,_____ am enrolled in Health Programs at Walters State Community College (WSCC).

Place initials beside each section.

I._____ Clinical Affiliates may require students carry health insurance. I must adhere to the requirements of the Clinical Affiliates I am assigned to as a Walters State Clinical Student.

II._____ I must be able to show proof of personal health insurance coverage should a Clinical Affiliate request to see it.

III._____ I am responsible for all costs incurred related to health insurance, health problems, or accidents that may occur while functioning in the role of a student.

IV._____ If I cannot meet the requirements of Clinical Affiliates to participate in the clinical portion of the course(s) in which I am currently enrolled, I will not be able to continue in the course(s).

V._____ I understand that should my insurance status change for any reason, I will notify the Health Programs Division immediately.

I hereby acknowledge by my signature below that I accept and understand the policies with which I must comply throughout my enrollment in WSCC Health Programs. I further acknowledge that I will comply with all policies outlined in this document and policies that are made known to me in other WSCC or clinical affiliate site documentation, including handbooks and syllabi. I acknowledge that I affirmatively agree to each of the provisions of this document as indicated by my initials beside each section of this Consent Form.

This in no way negates or limits policies and procedures in program specific material.

_____ _____
Student's Signature Date

_____
Student's Name (Print)

WALTERS STATE COMMUNITY COLLEGE
DEPARTMENT OF NURSING
CONSENT FORM

I,_____ am enrolled in the Nursing program at Walters State Community College (WSCC). I acknowledge receipt and understanding of the Walters State Community College Nursing Program Student Handbook. My signature indicates that I have read and understood this consent and release, and I have signed it voluntarily in consideration of enrollment in the Nursing Program at Walters State Community college.

Place initials beside each section.

I._____ I have obtained a copy of the WSCC Nursing Program Student Handbook and catalog and agree to abide by the policies within.

II._____ I hereby give permission for the WSCC Department of Nursing to release information regarding my malpractice insurance policy and Basic Life Support course Completion to the clinical agency where I am assigned.

III._____ I hereby give permission for a copy of my current Health History and Physical or information from that document to be submitted to clinical facilities or their designees where I am assigned. I understand that this information will be released only by request of the clinical facility(s).

IV._____ I hereby give my permission for photocopying of my written work. I understand that this material is to be utilized by the faculty for curriculum evaluation and development. I understand that my name will not appear on the copy.

V._____ I give my permission to WSCC to release personal identifiable information to the clinical facilities for the purpose of clinical education.

VI.____ I have read the Standard Precautions Procedure. I agree by my signature to abide by the contents within.

VII.____ I understand that WSCC strongly recommends every student to carry health insurance and that I am responsible for all costs incurred related to health problems or accidents should these occur while functioning in the role of a student.

VIII.____ I hereby give my permission for the Walters State Community College Nursing Program to use (and/or reproduce) my image (photograph, video, etc.) for educational purposes only. The images that I allow relate directly to activities of the Nursing Program and will be used only to enhance my learning, the learning of other students, and assessment by faculty, curriculum evaluation and development, and publicity. These images will be retained by Walters State Community College.

I hereby acknowledge by my signature below that I accept and understand the policies with which I must comply throughout my enrollment in the WSCC Nursing Program. I further acknowledge that I will comply with all policies outlined in this document and policies that are made known to me in other WSCC or clinical affiliate site documentation, including handbooks and syllabi. I acknowledge that I affirmatively agree to each of the provisions of this document as indicated by my initials beside each section of this Consent Form.

_____ _____

Student's Signature Date

_____

Student's Name (Print)

WALTERS STATE COMMUNITY COLLEGE
DIVISON OF HEALTH PROGRAMS

AGREEMENT FOR STUDENTS IN THE HEALTH PROGRAMS AT WSCC REGARDING STUDENT CONDUCT

The WSCC Health Program student agrees to conduct himself or herself in a professional, honorable, and ethical manner.

I. Professional Behaviors

- A. Actively participates and accepts responsibility for learning
- B. Effectively communicates
- C. Demonstrates dependability
- D. Demonstrates appropriate adaptability
- E. Appropriately utilizes resources
- F. Maintains acceptable level of personal appearance

II. Honorable and Ethical Behaviors

- A. Demonstrates accountability for all actions
- B. Demonstrates respect in all situations
- C. Demonstrates ethical behavior in all situations

By accepting admission to the health programs as WSCC you are voluntarily agreeing to abide by the Student Conduct Agreement.

This in no way negates or limits policies and procedures in program specific material.

Student Signature _____

Date _____

WALTERS STATE COMMUNITY COLLEGE
NURSING PROGRAM
Student Confidentiality/Non-Disclosure Acknowledgement

Student_____

As a student in the Nursing Program, I understand that I will be working with medical records and confidential information for patients at various healthcare facilities.

I understand that healthcare facilities remind their employees and volunteers of their confidentiality obligations on a periodic basis to help ensure compliance, due to the significance of this issue.

The healthcare facility/facilities that I may be assigned to have a legal and ethical responsibility to safeguard the privacy of all patients and protect the confidentiality of their health information. In the course of my assignment at any healthcare facility that is an Affiliate of Walters State Community College, I may come into possession of confidential patient information.

Medical records are confidential, legal, personal documents. The contents of individual patient's medical records are to be kept strictly confidential. As a condition of my assignment, I hereby agree that, unless directed by my instructor, I will not at any time during or after my assignment with the Affiliate healthcare facility disclose any patient information to any person whatsoever or permit any person whatsoever to examine or make copies of any patient reports or other documents prepared by me, coming into my possession, or under my control, or use patient information, other that as necessary in the course of my assignment. When patient information must be discussed with other health care practitioners in the course of my work, I will use discretion to assure that such conversations cannot be overheard by others who are not involved in the patient's care.

Nursing students must also treat as confidential all information relating to the personal, financial, and business affairs of the healthcare facility and its employees.

I pledge not to discuss the contents of any patient's medical record or any confidential information which comes to my knowledge except when such discussion is relative to the learning experience. I further agree to abide by the Health Insurance Portability and Accountability Act (HIPAA) guidelines in effect at the individual healthcare facility to which I am assigned. I understand that a violation of confidentiality in any of the above-described areas may be grounds for dismissal from the Nursing Program. I also understand that I may be in violation of the regulations of the Health Insurance Portability and Accountability Act of 1996 as effective April 14, 2003.

_____

Student's Signature **Date**

WALTERS STATE COMMUNITY COLLEGE
AUTHORIZATION FOR RELEASE OF STUDENT INFORMATION AND ACKNOWLEDGEMENT

I, _____ hereby authorize Walters State Community College, ("Institution") including all employees, agents, and other persons professionally affiliated with Institution having information related to the results of my background check and credential check(s) as these terms are generically used by background check agencies, hospitals, clinics and similar medical treatment facilities, to disclose the same to such facilities and the appropriate institutional administrators and faculty providing clinical instruction at such facilities, waiving all legal rights to confidentiality and privacy.

I expressly authorize disclosure of this information, and expressly release Institution, its agents, employees, and representatives from any and all liability in connection with any statement made, documents produced, or information disclosed concerning the same.

I understand that a hospital, clinic, or similar medical treatment facility may exclude me from clinical placement on the basis of a background check. I further understand that if I am excluded from clinical placement, I will not be able to meet course requirements and/or the requirements for graduation. I release Institution and its agents and employees from any and all liability in connection with any exclusion that results from information contained in a background check.

Any hospital, clinic or similar medical treatment facility to which I am assigned may be required by the Joint Commission on Accreditation of Healthcare Organizations' policy to conduct an annual compliance audit of five percent (5%) or a minimum of thirty (30) background investigation files. I agree that, upon request from a hospital, clinic or similar medical treatment facility to which I am assigned, I will provide the results of my background check to be used for audit purposes only.

_____
Student Signature

_____
Print Name

_____
Date

Consent to Drug/Alcohol Testing
Statement of Acknowledgment and Understanding
Release of Liability

I, _____ am enrolled in the Allied Health and/or Nursing program at Walters State Community College. I acknowledge receipt and understanding of the institutional policy with regard to drug and alcohol testing, and the potential disciplinary sanctions which may be imposed for violation of such policy as stated in the Walters State Community College Student Handbook.

I understand the purpose of this policy is to provide a safe working and learning environment for patients, students, clinical and institutional staff; and property. Accordingly, I understand that prior to participation in the clinical experience, I may be required to undergo drug/alcohol testing of my blood or urine. I further understand that I am also subject to testing based on reasonable suspicion that I am using or am under the influence of drugs or alcohol.

I acknowledge and understand the intention to test for drugs and/or alcohol and agree to be bound by this policy. I hereby consent to such testing and understand that refusal to submit to testing or a positive result of the testing may affect my ability to participate in a clinical experience, and may also result in disciplinary action up to and including dismissal from Walters State Community College.

If I am a licensed health profession, I understand that the state licensing agency will be contacted if I refuse to submit to testing or if my test results are positive. Full reinstatement of my license would be required for unrestricted return to the Walters State Community College Allied Health and/or Nursing Program.

My signature below indicates that:
I consent to drug/alcohol testing as required by clinical agencies or as directed by the Office of Student Affairs.
I authorize the release of all information and records, including test results relating to the screening or testing of my blood/urine specimen, to the Office of Student Affairs, the Director of the Allied Health and/or Nursing Program, and others deemed to have a need to know.
I understand that I am subject to the terms of the general regulation on student conduct and disciplinary sanctions of Walters State Community College, and the Drug-Free Campus/Workplace Policy of Walters State Community College, as well as, federal, state and local laws regarding drugs and alcohol.
I hereby release and agree to hold harmless Walters State Community College and the Tennessee Board of Regents, their officers, employees and agents from any and all action, claim, demand, damages, or costs arising from such test(s), in connection with, but not limited to, the testing procedure, analysis, the accuracy of the analysis, and the disclosure of the results.

My signature indicated that I have read and understand this consent and release, and that I have signed it voluntarily in consideration of enrollment in the Allied Health and/or Nursing Program at Walters State Community College.

_____ _____

Student's Signature **Date**