



STUDENT NAME: (Please Print)			DATE OF BIRTH:		SOCIAL SECURITY NUMBER:	
Last Name	First Name	Middle Initial	MM/DD/YYYY		XXX-XX-XXXX	
CONTACT INFO:						
Street Address			City		Zip Code	
Email address			Emergency Contact Name			(Area Code) Phone Number
TYPE OF STUDENT: NURSING: <input type="checkbox"/> RN <input type="checkbox"/> BSN <input type="checkbox"/> ABSN <input type="checkbox"/> MSN <input type="checkbox"/> CNS <input type="checkbox"/> NP <input type="checkbox"/> LVN			DESIRED PLACEMENT DATES:			
OTHER ALLIED HEALTH: <input type="checkbox"/> _____			START: _____		END: _____	
NURSING LICENSE: (IF APPLICABLE) EXP: _____			LIABILITY INSURANCE: (SCHOOL OR STUDENT) EXP: _____		BACKGROUND CHECK: _____	
			DRUG PANEL SCREENING: _____			

IMMUNIZATION HEALTH RECORDS MUST BE ATTACHED PER CHECKLIST BELOW:

Immunization Requirements	Titer Dates and Results	Vaccination Dates
COVID Vaccinated, plus Booster *if one dose Johnson & Johnson, then the second dose must be either Pfizer or Moderna.		Date: _____ Date: _____ Date: _____
2 Negative TB Skin Tests (PPD) (1) Must be within the last 2-years; and (2) to cover rotation period – dated within 1-year before end of rotation *If positive, must have Chest X-ray	#1 (TB Test) Date: _____ Results: _____ #2 (TB Test) Date: _____ Results: _____	Chest X-ray Date: _____ Results: _____ *TB Symptom Questionnaire must be within 3-months of start date: _____
TB Blood Test – QuantiFERON *Result must be negative (within 1-year) *If positive, must have chest x-ray	Date: _____ Results: _____	
MMR (Measles/Mumps/Rubella) *Must have positive MMR titer *Negative titer requires 2 MMR vaccinations one month apart	Positive MMR Titer Date: _____	*If NEGATIVE titer (must have 2 if born after 1957) #1 MMR Date: _____ #2 MMR Date: _____
Varicella *Requires positive titer *Negative titer requires 2 doses of varicella at least 1-2 months apart	Positive Varicella Titer Date: _____	*If NEGATIVE titer #1 Varicella Date: _____ #2 Varicella Date: _____
Hepatitis B *Requires positive Hep. B titer Requirements: Series 1 and 2 are one month apart. Series 3 is six months after Series 2	Positive Hepatitis B Titer Date: _____	*If NEGATIVE titer #1 Hep. B Date: _____ #2 Hep. B Date: _____ #3 Hep. B Date: _____
Tdap *Adult dose within the last 10 years	Date: _____	
Flu Vaccine *Influenza for current calendar year	Date: _____	Flu Attestation/Declination Signed Date: _____
BLS CPR CERTIFICATION: (please provide copy -- front and back)	Type: _____	Date Expires: _____

I CERTIFY THAT I HAVE VALIDATED THE INFORMATION REFERENCED ABOVE FOR THE STUDENT INDICATED ON THIS DOCUMENT.

Verified by: _____

Date: _____

Faculty / Instructor Signature

BACKGROUND CHECK-

Criminal Background Check and Drug Screening are required for all students placed at a Northern California Kaiser Permanente Medical Center, Outpatient Clinic/Medical Office Building, Home Health & Hospice, or Appt & Advice Call Center.

Effective 1/1/2008, a student with a background check that indicates any of the following felony and/or misdemeanor convictions within the last 7 years is NOT eligible for clinical placement:

- *Violent crimes such as murder, rape, sexual assault and robbery, kidnapping, attempted murder, assault with deadly weapons.*
- *Crimes involving theft, embezzlement, burglary, forgery, fraud, arson, identity theft.*
- *Sex crimes including sexual molestation and sex crimes against children, or any conviction for which a candidate is required to register as a sex offender with a state or federal government agency.*
- *Drug related crimes such as drug theft, sales, distribution, manufacturing and possession of controlled substances.*
- *Multiple convictions (more than one conviction for same or different crime).*
- *Name posted on any government sanctioned or debarred list.*

Do Not Submit this Page with Packet