Requirements for Practice in Clinical Facilities

Student's Last Name & Student's First Name - Write his/her last and first name in the spaces provided

Physical Examination Clearance Date – Write the date of his/her last physical examination. Physical exams must be done every two years.

Tuberculosis Clearance Date – Write the date of the student's last tuberculosis skin test (if PPD negative) or chest x-ray (if PPD positive). TST/PPD must be done on an annual basis.

Documentation of Immunity to Measles, Mumps and Rubella – Write the date of laboratory evidence to measles, mumps or rubella immunity (titer) or dates of appropriate vaccination against measles, mumps & rubella

Documentation of Immunity to Varicella – Write the date of laboratory evidence to varicella (titer) or dates of appropriate vaccination against varicella. Serological tests are needed if person has had the disease. Do not write "disease" as this is not acceptable.

Documentation of Hepatitis B Immunity - Write dates of appropriate vaccination against Hepatitis B disease (Administration of 3 dose series of Hepatitis B Vaccine at 0, 1, and 6 month intervals). Write date of titer if titer was drawn 1-2 months after dose #3.

HIPAA Modules Date – Write date when instructor and each student submitted the HIPAA Stimulus and HIPAA Compliance self-learning module certificates to Nursing Administration.

BLS for Healthcare Providers Expiration Date – Date of expiration of his/her CPR card.

Live Scan Date – Leave blank. DPH HR has this on file.

Malpractice Insurance Policy & Expiration Date – Name of policy & expiration date.

CA Driver's License & Expiration Date – Driver's license number & date of expiration.

Car Insurance Policy & Expiration Date – Name of car insurance company and policy number & date of expiration.

Instructor Info – Complete the same items for yourself on last row. Provide your school with copies of all information as this will be needed for contract monitoring.

Los Angeles County, Public Health Nursing
Requirements for Practice in Clinical Facilities

Affiliated College/University: ____ **Clinical Instructor:** ___________________________________

Public Health Clinical Site:____ **Clinical Dates:**_______________________________________

Student's Last Name	Student's First Name	Physical Exam Clearance Date	TB Clearance date (Baseline CXR/ Annual Negative	Measles vaccine /titer date and results	Mums vaccine/titer date and results	Rubella vaccine/ titer date	Varicella/ vaccine/ titer date and results	Hepatitis B titer date and results	Hepatitis B 1st dose vaccine date	Hepatitis B 2nd dose vaccine date	Hepatitis B 3rd dose vaccine date	HIPAA Stimulus Completion Date	HIPAA Compliance Completion Date	BLS Exp date	Live Scan	Malpractice Insurance Policy Name & Exp date	CA Driver's License & Exp date	Car Insurance Policy Name & Exp date
															On File with DPH HR			
Instructor Info																		

- Note: All students on this list have been found competent and physically fit to perform the clinical objectives.
- Note: The last line in the grid is for the instructor's information.

* **This Form must be submitted by no later than the second clinical week to:** Manager, Recruitment & Retention Unit universityaffiliates@ph.lacounty.gov

I ______________________________ (print name of instructor), RN License Number:____________ have met the above criteria. Signature: ____________________________________ Date: __________________

Revised: 7/03/2012 LMR