SCHOOL OF HEALTH PROFESSIONS AND NATURAL SCIENCES

CLINICAL CLEARANCE REQUIREMENTS HANDBOOK

FOR

NURSING, PARAMEDIC SCIENCE, RADIOGRAPHY AND RESPIRATORY THERAPY STUDENTS

REVISED 7.13.2023

Clinical Clearance Requirements Handbook

Introduction

The information contained in this handbook applies to COUNTY COLLEGE OF MORRIS (CCM) students who have been admitted into the professional phase of the following Health Professions Programs:

Nursing
Paramedic Science
Radiography
Respiratory Therapy

CCM maintains Clinical Affiliation Agreements with healthcare facilities in order to provide clinical experiences that are necessary components of the health professions programs. CCM is required to abide by the requirements set forth in these agreements to ensure the health and safety of patients, staff, students and faculty.

The following pages contain detailed instructions and procedures regarding the clinical clearance requirements. These requirements **MUST** be met by students enrolling/enrolled in all clinical courses. **Urine Drug Screens must be completed 45 days prior to the start of the semester.** All other clinical clearance documentation must be submitted within **30 days prior to the start of the semester** in order to continue in the professional phase of the program. In addition, if at any time during the course, requirements are not met, the student will be required to withdraw from the course.

Read the entire contents of this handbook carefully in order to understand and proceed with compliance.

Students should maintain the original documents for their files. No documents should be mailed or faxed to CCM. Documents should be reviewed prior to electronic submission to check for readability.

Students must include their Health Professions Program in the subject line and clear copies of all documentation should be delivered to:

Health Professions and Natural Sciences
HPNS -Office of the Dean
Clinical Clearance
Email: clinicalclearance@ccm.edu

*The Health Professions and Natural Sciences department reserves the right to change or modify any of this information at any time.

CRIMINAL HISTORY BACKGROUND CHECK

Students in the professional phase are required to submit to a Criminal History Background Check (CHBC) on an **annual** basis. All reinstated students are required to submit a new background check prior to re-entering the program. The search will include national, state, and local records. The cost of the CHBC is covered through student fees. Background investigations must be completed by TABB, Inc.

During the orientation session, students will complete required forms and authorizations for the CHBC to be processed. Students must open an account with TABB and order the required reports through their web-based system. TABB will send results to CCM in approximately 4-8 weeks.

Radiography students will submit their required forms and authorizations during their orientation session. Documents will be processed by the program director.

Results:

- "No Record Found". This indicates a clear record, and there is no further action required on the part of the student.
- "Record Found". This is considered a positive result. If a CHBC report indicates a "Record Found," the procedure for "Record Found" is followed. See below.
- "Pending". Results are considered positive while processing.
- "Outstanding". Charges that are outstanding that have not yet been processed or taken to court are considered positive until complete.
- All charges (records) that are in the process of expungement, trial or other are considered positive and must be fully resolved as evidenced by a "No Record Found" on the CHBC.
- When a "Record is Found", the seat may be held for one (1) semester depending upon the nature of the record. The time required to obtain a decision from the clinical site may take several months.

Students are required to report any arrest or conviction that occurs while in the program immediately to the department chair. The department chair will report this information to the security services director (or other designated person) at the clinical site to which the student is assigned. The student may be required to exit the course/program.

"Record Found" Procedure and Policy:

If CCM receives a report indicating a "Record Found", the department chair of the program will notify the student by email.

Review of the report is performed by the security services director or other identified department of the clinical affiliates. Upon receipt and review, the clinical affiliate may:

- Render a decision.
- Require additional information and communication with the student.
- Require a panel review at the clinical site.
- Decisions are final and will be rendered solely by the clinical site.

The process of CHBC record review can take up to 8-12 weeks. Therefore, a student's seat may be held for one (1) semester depending on the nature of the record to allow processing and resolution. A student students' seat in the professional program could be forfeited due to a "record found" report.

When a graduate applies for licensure as a registered nurse, radiologic technologist or respiratory therapist in New Jersey, the licensing and/or credentialing board will also require a CHBC. If the CHBC reveals a conviction, a review of the offense by the licensing and/or credentialing board may be required and may delay the licensure or credentialing process.

Fingerprinting:

Fingerprints may be required by some clinical facilities. Students will be notified as to which facilities require fingerprints. Students will incur this cost.

Additional Criminal Background Requirements for <u>Paramedic Students</u>

Applicants who answer affirmatively to the criminal background screening question shall be given a "Request for Criminal History Record Information for a Noncriminal Justice Purpose" (SBI 212B Form). This form will be required to be completed and delivered to NJDOH OEMS (N.J.A.C.8:41A-3.2.b).

Falsification of documents is cause for immediate removal from the course and the profession.

Students are required to submit the required forms and authorizations for the CHBC to be completed with their application packet. The College will submit the forms and authorizations to TABB who will send the results to the College in approximately 4-8 weeks.

Students are required to report any arrest or conviction that occurs while in the program immediately. The student shall be given a "Request for Criminal History Record Information for a Noncriminal Justice Purpose" (SBI 212B Form). This form will be required to be completed and delivered to NJDOH OEMS (N.J.A.C.8:41A-3.2b.). The student may be required to exit the program.

Driver's Abstract for Paramedic Students

All applicants are required to submit a current driver's abstract at the time of application. It is the student's responsibility to check with the hospital sponsor regarding how this will be funded. If a student is currently employed by the prospective sponsor, the sponsor may, at their discretion, utilize the student's current employment driver's abstract to fulfill this requirement. Students shall request a driver's abstract using the following NJ State website: http://www.state.nj.us/mvc/Licenses/DriverHistory.htm.

The student must notify the Program Director of any changes to the driver's abstract after application to the program. Clinical sites may conduct its own driver's abstract, in accordance with its policies, at any time while the student is enrolled in the program. Operating an emergency vehicle is a required skill for the field internship, and for the profession; failure to maintain a satisfactory driving record may jeopardize your ability to continue in the Paramedic Program.

DRUG AND ALCOHOL SCREENING

Students in the professional phase are required to undergo a 13-panel urine drug screening on a one-time basis. This should be submitted within 14 days of the request made by the specific program (Nursing, Respiratory Therapy, Radiography or Paramedic Science). All reinstated students are required to undergo the same procedure. The screen includes the following drugs:

- Amphetamines/Methamphetamine, Barbiturates, Benzodiazepines, Cannabinoids, Benzoylecgonine-Cocaine Metabolite, Opiate, Phencyclidine, Methadone, Propoxyphene, MDMA/MDA, Methaqualone, Meperidine, Tramadol

In the event of behavior deemed inappropriate or suspicious for impairment in any clinical course, the College reserves the right to refer the student for a random drug and alcohol screen. All costs of initial and additional screenings will be incurred by the student.

Drug screens must be completed by:
FastER Urgent Care
130 Speedwell Avenue
Morris Plains, New Jersey 07950
862-242-8053.

Students should contact the facility for current hours. Walk-ins only.

The ***Health Programs Urine Drug Screening*** form must be completed by the student and signed by a FastER Urgent Care representative on the day the test is performed and returned to the Clinical Clearance Department. The cost of the screen is $70 payable on the day of testing. Health insurance does not cover this cost as it is considered forensic. A sample of the form is included at the end of this document.

Drug Screening Results:

Test results are sent directly to the college by FastER Urgent Care.

Students who have ***Positive*** drug screenings will be contacted by the college's Medical Review Officer (MRO).

A review will be performed by the MRO that may include communication with the student as well as the prescribing physician. Medical records and other documentation may be required as part of the review process. This documentation will be required to come directly from the student's healthcare provider to the MRO. If the MRO determines that the results are positive, then the student will be notified, and the results reviewed with the MRO. Consequences can include immediate dismissal from the program. Positive screen for cannabinoids requires follow up by the department Chair and clinical affiliates as noted below. The student has five (5) business days from receipt of the dismissal notification to submit an appeal.

Appeals:

The student has the right to appeal the decision to the Dean of Health Professions and Natural Sciences and the Senior Vice President of Academic Affairs, Workforce Development and Student Success. This appeal must be in writing and must be submitted within five (5) business days of receipt of notification of the department chair's determination. The decision of the Senior Vice President of Academic Affairs, Workforce Development and Student Success is final.

In the event of a failed appeal or no appeal, the student is prohibited from enrolling in the college's Health Professions Programs in the future.

CERTIFICATE OF PROFESSIONAL LIABILITY INSURANCE
(STUDENT MALPRACTICE INSURANCE)

All students must carry current student malpractice insurance**. Insurance must be in effect by the first day of the semester**. Student malpractice insurance must be renewed annually as terms of these policies are in effect for one year. A copy of the Certificate of Insurance declaration page must be provided. Samples of a Certificate of Insurance declaration page are included at the end of this document. Listed below are the requirements and recommended vendors for each of the programs.

For Nursing Students:

Professional liability insurance of $2,000,000 each claim and $4,000,000 aggregate is required. Nursing students can purchase Malpractice Insurance from one of the following carriers or a carrier of their choice:

Cotterell, Mitchell & Fifer, Inc.
151 William Street
New York, New York 10038
(212) 233-8911
www.cmfgroup.com

Nurses Service Organization
159 E. County Line Road
Hatboro, Pennsylvania 19040
(800) 247-1500
www.nso.com

For Radiography Students:

Professional liability insurance of $2,000,000 each claim and $4,000,000 aggregate is required. Radiography students can purchase Malpractice Insurance from one of the following carriers or a carrier of their choice:

Healthcare Providers Service Organization (HPS0)
1100 Virginia Drive Suite 250
Fort Washington, PA 19034
Phone 1-800-982-9491
Fax # 1-800-739-8818
www.hpso.com
email: service@HPSO.com

For Paramedic Students:

Professional liability insurance of $3,000,000 each claim and $6,000,000 aggregate is required. Paramedic students can purchase Malpractice Insurance from one of the following carriers or a carrier of their choice:

Healthcare Providers Service Organization (HPS0)
1100 Virginia Drive Suite 250
Fort Washington, PA 19034
Phone 1-800-982-9491
Fax # 1-800-739-8818
www.hpso.com
email: service@HPSO.com

For Respiratory Therapy Students:

Professional liability insurance of $2,000,000 each claim and $4,000,000 aggregate is required. Respiratory can purchase Malpractice Insurance from one of the following carriers or a carrier of their choice:

https://proliability.mercer.com/ahc/prol/?APPLICATION=PROL&professionCode=STUDENT&associationAbbreviation=STIP-S&_ga=2.164839551.1381048778.1528923679-80605157.1528923679&isRedirected=y

AMERICAN HEART ASSOCIATION
BASIC LIFE SUPPORT (BLS)

Students are required to submit a copy of a current American Heart Association Basic Life Support (BLS). Certification by the American Red Cross or BLS Heartsaver is **NOT** acceptable.

The American Heart Association's BLS Course is designed for healthcare professionals and other personnel who need to know how to perform CPR and other basic cardiovascular life support skills in a wide variety of in-facility and prehospital settings.

Training is available at CCM through the Center for Workforce Development.
For more details go to https://www.ccm.edu/workforce/health/clinical/#cpr. The course is listed in the Continuing Professional Education Catalog. Seats are limited.

The following facilities provide American Heart Association CPR Certification:

Atlantic Health System	908-522-2323	https://www.atlantichealth.org/patients-visitors/education-support/first-aid-training.html
RWJBarnabas Health, Inc.	908-248-4639	https://www.rwjbh.org/treatment-care/training-center/healthcare-provider-classes/bls-for-healthcare-provider/

The student must provide a copy of the certification card. A sample American Heart Association Basic Life Support (BLS) provider card is included at the end of this document.

Paramedic Students Only:

All students must provide a copy of EMT certification. **EMT is a program enrollment requirement**. ACLS and PALS certifications will be provided as part of the curriculum.

All certifications and driver licenses are required to be maintained while enrolled in the program.

GUIDELINES FOR HEALTH CLEARANCE

The following information is based on **CDC Guidelines for Healthcare Personnel**. The links provided here are for your review. ALWAYS discuss your questions with your healthcare provider.

https://www.cdc.gov/mmwr/pdf/rr/rr6007.pdf
https://www.cdc.gov/vaccines/hcp/vis/current-vis.html
https://www.cdc.gov/coronavirus/2019-ncov/index.html
https://www.cdc.gov/breastfeeding/recommendations/vaccinations.htm

NOTE TO FEMALES OF CHILDBEARING AGE

Women who are pregnant or contemplating pregnancy should consult their healthcare provider for the following health clearance requirements.

MEDICAL HISTORY AND PHYSICAL EXAMINATION

Students in the profession phase are required to submit a physical examination on an annual basis. The physical examination and medical history must be completed by a licensed healthcare provider indicating that the student is in good physical and mental health and can participate in the clinical setting without limitations.

The ***CCM Health Programs Medical History and Physical Examination*** form must be completed no more than 60 days prior to the beginning of the program and signed by a licensed healthcare provider. A sample of the form is included at the end of this document.

Paramedic Students must complete the additional **CCM Health Programs Medical History and Physical Examination** form. A sample of this form is included at the end of this document.

COVID-19 VACCINATION STATUS

Students must complete the ***COVID-19 Vaccination Attestation*** form. A sample of the form is included at the end of this document.

Students who are fully vaccinated, must submit proof of vaccination. Students must submit the front and back of the Covid vaccine card or documentation of the doses administered. "**Fully vaccinated**" means a person has received all recommended doses in their primary series of COVID-19 vaccine and booster when eligible.

Students who are unvaccinated must provide documentation to support a medical or religious exemption and should be submitted directly to the clinical clearance coordinator.

Due to ongoing changes related to COVID-19, additional requirements may be imposed by clinical institutions related to COVID-19 screening and testing. Students will be notified of these requirements as they occur.

Paramedic students: The COVID-19 vaccine is **mandatory** for the program.

RESPIRATORY EVALUATION

Professional phase students are required to complete the OSHA Respiratory Medical Evaluation Questionnaire. This questionnaire is evaluated by the examining health care practitioner. Health Care Practitioner must provide approval for use of N95 Respirator. A sample of these forms are included at the end of this document.

OSHA Respirator Medical Evaluation Questionnaire and Health Care Practitioner Verification Statement

MEDICAL HEALTH INSURANCE

Students are required to carry personal health insurance which provides coverage for both accident and sickness. The college does not provide for the purchase of health insurance. For questions about obtaining health insurance, contact the Clinical Clearance Coordinator (CH 300) at clinicalclearance@ccm.edu or 973-328-5144.

Students must sign an ***Attestation of Health Insurance Coverage Form*** stating they will retain health insurance coverage throughout the program. A sample of the form is included at the end of this document.

AUTHORIZATION OF MEDICAL RELEASE

Students are required to authorize County College of Morris to release and disclose any and/or all pertinent medical information contained in their health clearance packet to the clinical facility and/or regulating agency that requires this information as a condition of their assignment to the facility.

This document will remain in effect through the entirety of their enrollment in the professional phase of the Nursing, Radiography, Respiratory Therapy and/or other health-related program for up to a two-year period from the date of signature.

Students must sign an ***Authorization for Medical Release Form***. A sample of the form is included at the end of this document.

TUBERCULOSIS TESTING

Tuberculosis (TB) is a disease caused by a germ called *Mycobacterium tuberculosis* that is spread from person to person through the air. TB usually affects the lungs, but it can also affect other parts of the body, such as the brain, the kidneys, or the spine. When a person with infectious TB coughs or sneezes, droplet nuclei containing *M. tuberculosis* are expelled into the air. If another person inhales air containing these droplet nuclei, he or she may become infected. However, not everyone infected with TB bacteria becomes sick. As a result, two TB-related conditions exist: latent TB infection and TB disease. Both these conditions must be treated. Although persons with latent TB infection cannot spread disease to others, treatment is necessary to prevent TB disease. Persons with TB disease are considered infectious and can spread TB bacteria to others. TB disease can lead to death.

TB testing helps ensure the health and safety of patients and healthcare providers.

Test required: Mantoux Tuberculin Skin Testing **OR** Interferon-Gamma Release Assay

Mantoux Tuberculin Skin Testing:

Mantoux Tuberculin Skin Testing (TST). The skin test reaction should be read between 48 and 72 hours after administration. Presence of induration (palpable, raised, hardened area or swelling) 5 mm or more may indicate a positive result.

- One step TST:
  - If documentation is provided of an annual TST within the previous year, a one-step TST is acceptable.
  - If documentation is provided of a negative IGRA, such as T-SPOT® or QuantiFERON®, within the previous year, a one-step TST is acceptable.
- Two-step TST: If there is no documentation of an annual TST within the previous year, a two-step TST must be performed. Two (2) TST procedures must be given within 1-3 weeks of each other.

Interferon-Gamma Release Assays (IGRAs)

Whole blood test.

- If an IGRA method is being used, a single blood test is required on an **annual** basis.

Results:

A ***Negative*** result is required.

If any TST or Interferon-Gamma Release Assays (IGRAs) are ***Positive*** and/or ***Indeterminate***, then documentation of the positive test must be provided, along with a report of a chest x-ray taken after the positive test indicating active or latent TB. If positive for active disease, they must receive the standard course of treatment. If Latent tuberculosis infection is present, documentation of adequate evaluation and/or treatment

is required. If evaluated with IGRAs, those results should be submitted in addition to the TST.

If a person has received the standard course of treatment for active or Latent TB and still presents a positive IGRA and negative chest x-ray, no further chest x-rays are needed. A completed *CCM Symptom Assessment for Pulmonary Tuberculosis* Form must be submitted annually. A sample form is included at the end of this document.

Information for persons who have received BCG vaccine:

IGRA testing is preferred for persons who have received BCG. Vaccination with BCG may cause a positive reaction to a TB skin test. A positive reaction to a TB skin test may be due to the BCG vaccine itself or due to an infection with TB bacteria. Persons who have had a BCG vaccine should consult their healthcare provider for tuberculosis test options.

Glossary:

BCG vaccine: Bacille Calmette-Guerin is a vaccine for tuberculosis (TB) disease. This vaccine is not widely used in the United States but is often given to infants and small children in other countries where TB is common. BCG does not always protect people from getting TB. TB blood tests (IGRAs), unlike the TB skin test, are not affected by prior BCG vaccination and are not expected to give a false-positive result in people who have received BCG.

TB: Tuberculosis

IGRA: Interferon-Gamma Release Assays. These are whole blood tests that can aid in diagnosing the *Mycobacterium tuberculosis* infection. There are two IGRAs that have been approved by the U.S. Food and Drug Administration (FDA) that are commercially available in the U.S.:

- QuantiFERON®-TB Gold In Tube test (QFT-GIT)
- T-SPOT®.*TB* test (T-Spot)

TST: Mantoux tuberculin skin test (may also be referred to as a PPD test or a Mantoux test). This is the standard method of determining whether a person is infected with *Mycobacterium tuberculosis*. The TST is performed by injecting 0.1 ml of tuberculin purified protein derivative (PPD) into the inner surface of the forearm. The test is an intradermal injection.

Documentation must be provided on the ***CCM Health Annual Tuberculosis Screening*** form and signed by a licensed healthcare provider.

This is an **annual** requirement.

MEASLES, MUMPS AND RUBELLA

Students must demonstrate **laboratory evidence of immunity** to Measles, Mumps, Rubella and Varicella. Proof of positive antibody titers (IgG) for each of these diseases is required. Antibody titer tests detect the amount of antibodies in the blood and can determine if a person has had a previous infection and whether or not immunizations are needed. When sufficient antibodies to a specific infection are present, this indicates that the person has immunity to that infection, thus helping to decrease the spread of disease. This protects the safety of patients and healthcare providers.

Only laboratory reports with titer results are acceptable evidence as proof of immunity. Documentation and/or proof of vaccination or evidence of disease will **NOT** be accepted as proof of immunity for measles, mumps, rubella and varicella.

Measles

Measles virus is a highly contagious virus and spreads through the air through coughing and sneezing. Measles is also referred to as rubeola, NOT to be confused with rubella. Severe complications, which might result in death, include pneumonia and encephalitis. Measles starts with fever, runny nose, cough, red eyes, and sore throat. It is followed by a rash that spreads over the body.

Test: blood test

Results required: ***Positive, Immune***. This indicates that sufficient rubeola/measles specific IgG antibodies have been detected thus providing immunity to measles. Low titers, as indicated as ***Equivocal*** or ***Non-Immune*** will require additional immunizations (or boosters) to provide the necessary immunity.

If individual is **not** immune, proof of administration of two doses of live measles (or MMR) vaccine, separated by at least 28 days must be submitted unless otherwise specified by a licensed healthcare provider and documentation is provided.

Documentation must be provided on the ***CCM Health Programs Immunization Record*** and signed by a licensed healthcare provider. A sample form is included at the end of this document.

Rubella

Rubella (sometimes referred to as “German measles”) is a viral disease characterized by rash, low-grade fever, lymphadenopathy, and malaise. Although rubella is considered a benign disease, transient arthralgia and arthritis are observed commonly in infected adults, particularly among postpubertal females. Of primary concern are the effects that rubella can have when a pregnant woman becomes infected, especially during the first trimester. This can result in miscarriages, stillbirths, therapeutic abortions, and congenital rubella

syndrome (CRS), a constellation of birth defects that often includes blindness, deafness, mental retardation, and congenital heart defects.
Test: blood test

Results required: ***Positive, Immune***. This indicates that sufficient rubella specific IgG antibodies have been detected thus providing immunity to rubella. Low titers, as indicated as ***Equivocal*** or ***Non-Immune*** will require additional immunizations (or boosters) to provide the necessary immunity.

If **not** immune, documentation of vaccination with 1 dose of live rubella virus-containing vaccine (or MMR) is required.

Documentation must be provided on the ***CCM Health Programs Immunization Record*** and signed by a licensed healthcare provider. A sample form is included at the end of this document.

Mumps

Mumps is an acute viral infection characterized by fever and inflammation of the salivary glands (usually parotitis). The spectrum of illness ranges from subclinical infection (20%–40%) to nonspecific respiratory illness, sialadenitis including classic parotitis, deafness, orchitis, and meningoencephalitis; severity increases with age.

Test: blood test

Results required: ***Positive, Immune***. This indicates that sufficient mumps specific IgG antibodies have been detected thus providing immunity to mumps. Low titers, as indicated as ***Equivocal*** or ***Non-Immune*** will require additional immunizations (or boosters) to provide the necessary immunity.

If **not** immune, documentation of vaccination with 2 doses of live mumps virus-containing vaccine (or MMR) at least one month apart is required unless otherwise specified by a licensed healthcare provider and documentation is provided.

Documentation must be provided on the ***CCM Health Programs Immunization Record*** and signed by a licensed healthcare provider. A sample form is included at the end of this document.

VARICELLA (CHICKENPOX)

Varicella is a highly infectious disease caused by primary infection with varicella-zoster virus (VZV). VZV is transmitted from person to person by direct contact, inhalation of aerosols from vesicular fluid of skin lesions of varicella or herpes zoster (HZ), a localized, generally painful vesicular rash commonly called shingles, or infected respiratory tract secretions that also might be aerosolized.

Test: blood test

Results required: ***Positive, Immune***. This indicates that sufficient varicella specific IgG antibodies have been detected thus providing immunity to varicella. Low titers, as indicated as ***Equivocal*** or ***Non-Immune*** will require additional immunizations (or boosters) to provide the necessary immunity.

If **not** immune, documentation of vaccination with 2 doses of varicella vaccine four to eight weeks apart is required unless otherwise specified by a licensed healthcare provider and documentation is provided.

Documentation must be provided on the ***CCM Health Programs Immunization Record*** and signed by a licensed healthcare provider. A sample form is included at the end of this document.

HEPATITIS B

Hepatitis B is an infection caused by the hepatitis B virus (HBV), which is transmitted through percutaneous (i.e., breaks in the skin) or mucosal (i.e., direct contact with mucous membranes) exposure to infectious blood or body fluids. The virus is highly infectious; for non-immune persons, disease transmission from a needlestick exposure is up to 100 times more likely for exposure to hepatitis B e-antigen (HBeAg)–positive blood than to HIV-positive blood. HBV infection is a well-recognized occupational risk for U.S. healthcare personnel and globally. The risk for HBV is associated with degree of contact with blood in the workplace and with the hepatitis B e-antigen status of the source persons. The virus is also environmentally stable, remaining infectious on environmental surfaces for at least 7 days.

Test: blood test

Results required: Proof of immunity as evidenced by **Positive** titers.

Titers: Proof of immunity to Hepatitis B indicated by a HBsAb titer value as ***Positive*** or ***Immune*** or ***Reactive***. ***Non-Immune*** or ***Non-Reactive*** titers require completion of a new 3-dose vaccine series or a 2 dose series as described below:

3-dose vaccine series: The 3-dose vaccine series is administered intramuscularly. The recommended adult immunization for a new 3-dose series for Hep B should be scheduled as the following:

The first dose should be given as soon as possible. The second dose will be administered 4 weeks after, and the third dose 5 months after the second dose.

2-dose vaccine series: Administer 2 doses at least 4 weeks apart

Attendance at clinical is permitted if the series is incomplete at the start of clinical. However, failure to complete the series will result in rescinding of clearance.

Non-responders: A non-responder refers to a person who does not develop protective surface antibodies after completing two full series of the hepatitis vaccine and for whom an acute or chronic hepatitis B infection has been ruled out. Students who are determined to be a non-responder, as evaluated by their Health Care Practitioner should submit the supporting documentation.

Documentation must be provided on the ***CCM Health Programs Immunization Record*** and signed by a licensed healthcare provider. A sample form is included at the end of this document.

TETANUS/DIPHTHERIA/ACELLULAR PERTUSSIS (TDAP)

Pertussis is a highly contagious bacterial infection. Secondary attack rates among susceptible household contacts exceed 80%. Transmission occurs by direct contact with respiratory secretions or large aerosolized droplets from the respiratory tract of infected persons.

Requirement: Evidence of Tdap vaccine at or after age 11.

This is a **one time** requirement

Tdap vaccine provides immunity for tetanus, diphtheria and acellular pertussis, hence the name Tdap. The Tdap vaccine is administered as a one time vaccination at or after 11 years of age.

Recommended: Although not required, it is recommended that all adults receive a Tdap containing routine booster every ten years to protect against tetanus and diphtheria.

Documentation must be provided on the ***CCM Health Programs Immunization Record*** and signed by a licensed healthcare provider. A sample form is included at the end of this document.

INFLUENZA VACCINATION

Influenza causes an estimated average of >200,000 hospitalizations and 3,000–49,000 deaths annually in the United States. The majority of influenza-related severe illnesses and deaths occurs among persons with chronic medical conditions, infants and young children, seniors, and pregnant women. Reducing the risk for influenza among persons at higher risk for complications is a major focus of influenza prevention strategies.

Test: No test is required.

Vaccination: Vaccination against the seasonal influenza virus is required. For most persons who need only one dose of influenza vaccine for the season, vaccination should ideally be

offered during the September and October months. Vaccination during July and August is not recommended and should be avoided.

For students admitted in the fall, vaccination must be administered by November 1st each year or as specified by the clinical affiliate.

For students admitted in the spring, vaccination must be administered by December 31st if not previously vaccinated prior to admission and by November 1st for each year thereafter.

Documentation of date of vaccination administration, manufacturer, product name, lot #, dose, injection site and name and signature of licensed healthcare provider administering the vaccine must be provided on the ***Health Programs Annual Influenza Vaccination*** form.

Any students who have not received their annual, seasonal flu vaccine due to medical exemption are required to wear a mask at all times while at all medical centers or any locations where patients are referred to or treated. The only exception to the wearing of a mask is during times when eating or drinking. Students must wear a mask when caring for, or when within six feet of a patient with flu-like symptoms.

This is an **annual** requirement.

NOTE

Certain vaccine series can take up to nine (9) months to build immunity. If a titer for a specific immunity is below immunity range, the student will maintain a seat provided the CDC vaccine schedule is followed.

□ Nursing □ CNA Semester/Year_____
□ Radiography □ Biomedical Engineering
□ Respiratory Therapy □ Paramedic Science

COUNTY COLLEGE OF MORRIS
Health Programs MEDICAL HISTORY AND PHYSICAL EXAMINATION

TO BE COMPLETED AND SIGNED BY STUDENT:

Last Name_____ First Name_____ MI_____ Student ID_____

Student Email_____ Phone_____ Date of Birth_____ Age_____

Drug Allergies _____ Food Allergies/Intolerance _____

Does student require EpiPen? □ Yes □ No Has student been trained in its use? □ Yes □ No

Medications (Please include prescription medications and any over-the-counter medications taken daily)_____

_____

Past Medical History_____

_____

Name of Emergency Contact_____ Relationship_____

Home Phone_____ Cell/Work Phone_____

Signature of Student_____ Date_____

TO BE COMPLETED AND SIGNED BY LICENSED HEALTHCARE PROVIDER: The information requested by the College is strictly for the use of authorized personnel and will not be released without the student's consent.

Male_____ Female_____ Height_____ Weight_____ Blood Pressure_____

Heart Rate_____ Hearing within Normal Limits □Yes □No Vision Right 20/_____ Left 20/_____

Corrective Lenses □ Yes □ No Color Blind □ Yes □ No

System	Satisfactory	Unsatisfactory	Details if Unsatisfactory
HEENT			
Respiratory			
Cardiovascular			
Gastrointestinal			
Hernia			
Genitourinary			
Musculoskeletal			
Metabolic/Endocrine			
Neuropsychiatric			
Skin			

Student is medically qualified to wear a N95 Respirator. □ Yes □ No

Student is cleared for all physical activities without limitations. □ Yes □ No

If no, please explain why_____

Licensed Healthcare Provider's Name _____ Date of Exam_____
Print

Signature of Licensed Healthcare Provider_____ Phone_____

Address _____

□ Nursing □ CNA Semester/Year_____
□ Radiography □ Biomedical Engineering
□ Respiratory Therapy □ Paramedic Science

COUNTY COLLEGE OF MORRIS
Health Programs IMMUNIZATION RECORD

Last Name_____ First Name_____ MI_____ Student ID_____

Student Email_____ Phone_____ Date of Birth_____ Age_____

TO BE COMPLETED AND SIGNED BY A LICENSED HEALTHCARE PROVIDER: All students must have titers* drawn. <u>All laboratory reports</u> must be attached for Rubeola (Measles), Mumps, Rubella, Varicella and HBsAb titers. Equivocal findings are documented as negative immunity.

***Past Titer Results are acceptable. Titers do not need to be repeated.**

Test	Drawn	IgG Titer Value	Revaccination* Date
Rubeola (Measles)	Date_____	Value_____ □ Positive □ Negative	(Re)vaccination #1 Date_____ (with documented series) (Re)vaccination #2 Date_____ (without documented series)
Mumps	Date_____	Value_____ □ Positive □ Negative	(Re)vaccination #1 Date_____ (with documented series) Revaccination #2 Date_____ (without documented series)
Rubella	Date_____	Value_____ □ Positive □ Negative	Revaccination #1 Date_____ (If Titer is Negative or Equivocal)
Varicella	Date_____	Value_____ □ Positive □ Negative	(Re)vaccination #1 Date_____ (with documented series) (Re)vaccination #2 Date_____ (without documented series)
Hepatitis B (HBsAb)	Date_____	Value_____ □ Immune □ Not-Immune	If HBsAb titer shows immunity, the student does not need to complete the three Hepatitis vaccine series. If HBsAb titer **<u>does not</u>** show immunity, three (3) documented doses of Hepatitis B vaccine must be presented or administered.
Hepatitis B	**Dates of Vaccinations** Three (3) doses of Hepatitis B vaccine administered intramuscularly at 0, 1 and 6 months.		
	#1	**#2**	**#3**

*Based on CDC recommendations for Healthcare Professionals

Tdap	Date_____	Student must have received a Tdap vaccine at 11 years of age or older.

Licensed Healthcare Provider's Name _____ Date of Exam_____
Print

Signature of Licensed Healthcare Provider_____

Address_____ Phone_____

_____

6.1.18 New
9/19/19 revised

□ Nursing □ CNA Semester/Year_____
□ Radiography □ Biomedical Engineering
□ Respiratory Therapy □ Paramedic Science

COUNTY COLLEGE OF MORRIS
HEALTH PROGRAMS ANNUAL TUBERCULOSIS SCREENING

Last Name_____ First Name_____ MI_____ Student ID_____

Student Email_____ Phone_____ Date of Birth_____ Age_____

TO BE COMPLETED AND SIGNED BY A LICENSED HEALTHCARE PROVIDER: Either a Mantoux TB (PPD) skin test OR an interferon gamma release assay (IGRA) blood test such as QuantiFERON Gold® or T-SPOT® is acceptable. A two-step PPD is necessary unless a PPD was done in the last calendar year. If a one-step PPD was done, documentation of the previous one-step done within the past calendar year must be attached. PPD RESULTS MUST BE RECORDED IN mm

Two-Step PPD (Mantoux) (Date Read must be within 72 hours)

PPD #1 Date Administered_____ Site _____ Date Read*_____ Result _____

PPD #2 (administered 1 to 3 weeks after PPD #1) is required unless student provides proof of a previous negative PPD within 1 year of the date of PPD #1 OR provides a negative T-Spot or QuantiFERON result from previous year.

PPD #2 Date Administered_____ Site _____ Date Read*_____ Result _____

*Date Read Must Be Within 72 hours

One-Step PPD (Mantoux)
Documentation of previous one-step done within the past calendar year must be attached.

PPD #1 Date Administered_____ Site _____ Date Read*_____ Result _____

*Date Read Must Be Within 72 hours

OR

IGRA (QuantiFERON)—TB Gold® or T-Spot® Blood Test Date Reported_____ Result_____
Lab Report Must Be Attached

PPD or QuantiFERON® or T-Spot® Positive Findings

Positive Result: If positive, a negative post-positive chest x-ray is required. This is a one-time only requirement as long as student is asymptomatic. An IGRA blood test is recommended for subsequent tuberculosis screening.

Chest x-ray has been documented post-positive result? ☐ Report Date_____ **Report Must Be Attached**

☐ Normal Chest x-ray

☐ Abnormal Chest x-ray ☐ Patient was/is treated with prophylactic medication. Date treatment started

Licensed Healthcare Provider's Name_____ Date_____

Signature of Licensed Healthcare Provider_____

Address _____ Phone_____

_____

6.1.18 New

□ Nursing □ CNA Semester/Year_____
□ Radiography □ Biomedical Engineering
□ Respiratory Therapy □ Paramedic Science

COUNTY COLLEGE OF MORRIS
Health Programs ANNUAL INFLUENZA VACCINATION

Last Name_____First Name_____MI_____Student/Faculty ID_____

Student/Faculty Email_____Phone_____Date of Birth_____Age_____

TO BE COMPLETED AND SIGNED BY A LICENSED HEALTHCARE PROVIDER
If documentation is being sent that includes all the information below, then indicate "See attached".

Date of Vaccine Administration_____

Manufacturer_____ Product Name_____

Lot_____ Expiration Date_____

Dose_____ Injection Site_____

Licensed Healthcare Provider's Name _____Title_____
Print

Signature of Licensed Healthcare Provider_____

Address_____Phone_____

_____

NOTE:
For students admitted in the fall, vaccination must be administered by **October 1st** each year.

For students admitted in the spring, vaccination must be administered by **December 31st if not previously vaccinated** prior to admission and by October 1st for each year thereafter.

6.1.18 New
9.16.2020 Rev

□ Nursing □ CNA Semester/Year_____
□ Radiography □ Biomedical Engineering
□ Respiratory Therapy □ Paramedic Science

COUNTY COLLEGE OF MORRIS
Health Programs URINE DRUG SCREENING

Last Name_____First Name_____MI_____Student ID_____

Student Email_____Phone_____Date of Birth_____Age_____

A 13-panel drug screen is mandatory for all students doing their clinical rotations at healthcare facilities. The screen includes the drugs listed below.

Amphetamines/ Methamphetamine	Barbiturates	Benzodiazepines	Cannabinoids
Benzoylecgonine- Cocaine Metabolite	Opiates	Phencyclidine	Methadone
Propoxyphene	MDMA/MDA	Methaqualone	Meperidine
Tramadol			

Failure to submit to drug screening will result in dismissal from the program. The drug screening MUST be completed at **FastER Urgent Care** (flyer attached). The cost is $70 payable on the day of testing. The student must bring this form to FastER Urgent Care and have it signed below by a FastER Urgent Care representative and submit it to the Administrative Assistant for Health Professions. Test results are sent directly to the College by FastER Urgent Care. For questions, students should refer to the Student Handbook or contact the Administrative Assistant for Health Professions.

As part of my pre-clinical requirement to ensure I am physically able to perform the clinical component of my program, I am required to provide a urine sample for an 13-panel drug screen to determine my status for illegal drug use.

I, _____, consent to providing a sample of my urine to be tested for drug content at **FastER Urgent Care.**

TO BE SIGNED BY A FastER URGENT CARE REPRESENTATIVE

Representative's Name _____Date of Test_____
Print

Signature of Representative_____

Address_____Phone_____

□ Nursing □ CNA Semester/Year_____
□ Radiography □ Biomedical Engineering
□ Respiratory Therapy □ Paramedic Science

COUNTY COLLEGE OF MORRIS
Health Programs ATTESTATION OF HEALTH INSURANCE COVERAGE

Last Name_____First Name_____MI_____Student ID_____

Student Email_____Phone_____Date of Birth_____Age_____

I, _____, attest that as required by County College of Morris, I have a
Print Full Name

current health insurance plan which I will maintain through the entirety of my enrollment in the professional phase of the Nursing, Radiography, Respiratory Therapy and/or other health-related program that require participation in a clinical experience. I understand that at any time I may be required to present proof of my health insurance plan.

Student Signature_____ Date_____

COUNTY COLLEGE OF MORRIS
Health Programs AUTHORIZATION FOR MEDICAL RELEASE

I, _____, authorize County College of Morris to release and disclose
Print Full Name

any and/or all pertinent medical information contained in my health clearance packet to the clinical facility and/or regulating agency that requires this information as a condition of my assignment to the facility.

This document will remain in effect through the entirety of my enrollment in the professional phase of the Nursing, Radiography, Respiratory Therapy and/or other health-related program for up to a two-year period from the date of signature.

Student Signature_____ Date_____

□ Nursing □ CNA Semester/Year:_____
□ Radiography □ Biomedical Engineering
□ Respiratory Therapy □ Paramedic Science

COUNTY COLLEGE OF MORRIS

CRIMINAL HISTORY BACKGROUND CHECK AND DRUG and ALCOHOL SCREENING
STUDENT ACKNOWLEDGEMENT FOR STUDENTS IN THE CLINICAL PHASE OF THE HEALTH PROFESSIONS PROGRAMS

I acknowledge that I have received written notification informing me that all students enrolled in clinical courses will be required to submit to a Criminal History Background Check (CHBC) and Urine Drug Screening as mandated by the clinical affiliation agreements.

The CHBC will occur on an annual basis. If there is a record found or a positive result, admission into the professional phase of the program may be denied. If at any time after acceptance into the professional phase of the program a student has a positive CHBC, it may result in dismissal from the program.

It is the policy of the Nursing, Radiography and Respiratory Therapy Programs that students report any arrest or conviction immediately to the department chairperson and that this information will be reported to the security services director (or other designated person) at the clinical site to which the student is assigned.

An 11-panel Urine Drug Screening will be performed upon acceptance into the clinical phase of the program. In the event of behavior deemed inappropriate or suspicious in any clinical course, the College reserves the right to refer the student for a random drug and alcohol screen. All costs of initial and additional screenings will be incurred by the student. Positive results may be cause for immediate dismissal from the program. Refusal to submit to drug and alcohol screenings will result in dismissal from the program. Campus Regulations regarding alcohol and drugs also apply.

Reinstated students must have a repeat CHBC and Urine Drug Screening completed upon re-entry into the program.

When a graduate applies for licensure as a registered nurse, radiologic technologist or respiratory therapist in New Jersey, another CHBC will be performed. If the CHBC reveals a conviction, a review of the offense by the licensing and/or credentialing board may be required and may delay the licensure or credentialing process.

_____ _____
Signature Date

_____ _____ _____
Print Name Student ID # Program

□ Nursing □ CNA Semester/Year_____
□ Radiography □ Biomedical Engineering
□ Respiratory Therapy □ Paramedic Science

COUNTY COLLEGE OF MORRIS
Health Programs COVID-19 VACCINATION ATTESTATION

Last Name_____First Name_____MI_____Student/Faculty ID_____

Student/Faculty Email_____Phone_____Date of Birth_____Age_____

I,_____, attest that (check only one box):
Print Full Name

☐ I am fully vaccinated.

"Fully vaccinated" means a person has received all recommended doses in their primary series of either the Moderna, Pfizer, or Johnson & Johnson COVID-19 Vaccine and a booster dose when eligible.

Date(s) of Vaccine Administration_____

COVID-19 Vaccine Manufacturer_____

☐ I am partially vaccinated.

I received the first dose of a two-dose COVID-19 vaccine on_____ and expect to receive the second dose on_____.
Date *Date*

I received the primary series on _____and expect to receive the booster on _____.
Date *Date*

☐ I am unvaccinated.

I have not received a COVID-19 vaccine.

***Fully vaccinated students must submit a copy of their COVID-19 Vaccine Record Card to clinicalclearance@ccm.edu.**

I confirm that the information I have provided is accurate and truthful to the best of my knowledge.

Student Signature_____ Date_____

NOTE:
Due to the ongoing changes related to the COVID-19 pandemic, additional requirements may be imposed by clinical institutions related to COVID-19 vaccination, screening, and testing. Students will be notified of these requirements as they occur. Documentation to support a student's medical or religious exemption should be provided directly to the clinicalclearance@ccm.edu or clinical facility as required.

FastER Urgent Care is a located across the street from the Alfred Vail School at 130 Speedwell Avenue on the corner of Mill Road in Morris Plains. We provide walk-in no appointment needed medical care to children and adults for a wide range of illness and injuries including:

- Cough/Colds/Flu/Strep Throat
- Ear Aches
- Fractures/Dislocations
- Sprains/Strains
- Lacerations, Burns and Skin Infections
- Urinary Tract Infections
- Gyn problems and STD Testing
- Vomiting/Diarrhea
- School/Camp/Sports/Work and Routine Physicals

We have onsite x-ray and rapid testing for strep, pregnancy, and flu, and full lab services

Open Monday-Friday 8am-8pm*

Saturday and Sunday 8am-4pm*

Major Holidays 9am-1pm

***Drug Testing stops at 5pm on weekdays and 1pm on weekends**

New Jersey Department of Health

Symptom Assessment for Pulmonary Tuberculosis (TB)

Name *(Last, First, MI)*		Birthdate *(mm/dd/yyyy)*
Street Address		Telephone Number
City	State	Zip Code
Date of Symptom Assessment *(mm/dd/yyyy)*		

TB-Like Symptoms *(Check all that apply)*:

- ☐ Productive Cough of Undiagnosed Cause (more than 3 weeks in duration)
- ☐ Coughing Up Blood (Hemoptysis)
- ☐ Unexplained Weight Loss (10 pounds or greater without dieting)
- ☐ Night Sweats (regardless of room temperature)
- ☐ Unexplained Loss of Appetite
- ☐ Very Easily Tired (Fatigability)
- ☐ Fever
- ☐ Chills
- ☐ Chest Pain

If any symptoms are reported a chest radiograph and medical evaluation is needed.

☐ **No TB-Like Symptoms Reported or Observed**

Name of Licensed MD/RN *(Print)*	
Signature of Licensed MD/RN	Date

OSHA Respirator Medical Evaluation Questionnaire (Mandatory)
OSHA Respirator Medical Evaluation Questionnaire (Mandatory)
Appendix C to sec. 1910.134

PLEASE COMPLETE ALL QUESTIONs COMPLETELY, WITH EXPLANATIONS WHERE REQUESTED. PRINT YOUR NAME CLEARLY IN QUESTION #2

To the employee/student:

Can you read ☐ Yes ☐ No

Part A. Section 1. (Mandatory) The following information must be provided by every employee who has been selected to use any type of respirator (***please print clearly***).

1. Today's Date: _____
2. Your Name and SS#: _____
4. Sex: ☐ Male ☐ Female
5. Your Height: _____ ft. _____ in.
6. Your Weight: _____ lbs.
7. Your Department/Job Title: _____
8. Telephone numbers (Including area code): Work _____ Home _____
Cell _____

9. **The best time to reach you by phone between the hours of 7:00 am and 3:00 pm**: _____
At which number (Circle): Work Home Cell.

10. Has your employer/program director told you how to contact the health care professional who will review this questionnaire (check one): ☑*Yes* ☐No You ***may contact your Site OMS Office***

11. Check the type of respirator you will use (you can check more than one category):

a. ☐ N-95, R, or P disposable respirator (filter-mask, **non-cartridge** type only).
b. ☐ Other type (for example, half- or full-face piece type, powered-air purifying, supplied-air, self-contained breathing apparatus).

12. Have you worn a respirator before? ☐ **Yes** ☐ **No**

If "Yes" what type(s):
_____
_____

Part A. Section 2. (Mandatory) Questions 1 through 9 below must be answered by every employee/student who has been selected to use any type of respirator (please mark "yes" or "no").

1. Do you ***currently*** smoke tobacco, or have you smoked tobacco in the last month: ☐ **Yes** ☐ **No**

2. Have you ***ever had*** any of the following conditions?

a. Seizures (fits): ☐ **Yes** ☐ **No**

b. Diabetes (sugar disease): ☐ **Yes** ☐ **No**
c. Allergic reactions that interfere with your breathing: ☐ **Yes** ☐ **No**
d. Claustrophobia (fear of closed-in places): ☐ **Yes** ☐ **No**
e. Trouble smelling odors: ☐ **Yes** ☐ **No**

If you answered yes to any above question please explain.

_____

_____

_____

3. Have you ***ever had*** any of the following pulmonary or lung problems?

a. Asbestosis: ☐ **Yes** ☐ **No**
b. Asthma: ☐ **Yes** ☐ **No**
c. Chronic bronchitis: ☐ **Yes** ☐ **No**
d. Emphysema: ☐ **Yes** ☐ **No**
e. Pneumonia: ☐ **Yes** ☐ **No**
f. Tuberculosis: ☐ **Yes** ☐ **No**
g. Silicosis: ☐ **Yes** ☐ **No**
h. Pneumothorax (collapsed lung): ☐ **Yes** ☐ **No**
i. Lung cancer: ☐ **Yes** ☐ **No**
j. Broken ribs: ☐ **Yes** ☐ **No**
k. Any chest injuries or surgeries: ☐ **Yes** ☐ **No**
l. Any other lung problem that you've been told about: ☐ **Yes** ☐ **No**

If you answered yes to any above question please explain and list any medical attention you have received:

_____

_____

_____

4. Do you ***currently*** have any of the following symptoms of pulmonary or lung illness?

a. Shortness of breath: ☐ **Yes** ☐ **No**
b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline: ☐ **Yes** ☐ **No**
c. Shortness of breath when walking with other people at an ordinary pace on level ground: ☐ **Yes** ☐ **No**
d. Have to stop for breath when walking at your own pace on level ground: ☐ **Yes** ☐ **No**
e. Shortness of breath when washing or dressing yourself: ☐ **Yes** ☐ **No**
f. Shortness of breath that interferes with your job: ☐ **Yes** ☐ **No**
g. Coughing that produces phlegm (thick sputum): ☐ **Yes** ☐ **No**
h. Coughing that wakes you early in the morning: ☐ **Yes** ☐ **No**
i. Coughing that occurs mostly when you are lying down: ☐ **Yes** ☐ **No**
j. Coughing up blood in the last month: ☐ **Yes** ☐ **No**
k. Wheezing: ☐ **Yes** ☐ **No**
l. Wheezing that interferes with your job: ☐ **Yes** ☐ **No**
m. Chest pain when you breathe deeply: ☐ **Yes** ☐ **No**

n. Any other symptoms that you think may be related to lung problems: ☐ **Yes** ☐ **No**

If you answered yes to any above question please explain and did you seek medical attention:

5. Have you ***ever had*** any of the following cardiovascular or heart problems?

a. Heart attack: ☐ **Yes** ☐ **No**
b. Stroke: ☐ **Yes** ☐ **No**
c. Angina: ☐ **Yes** ☐ **No**
d. Heart failure: ☐ **Yes** ☐ **No**
e. Swelling in your legs or feet (not caused by walking): ☐ **Yes** ☐ **No**
f. Heart arrhythmia (heart beating irregularly): ☐ **Yes** ☐ **No**
g. High blood pressure: ☐ **Yes** ☐ **No**
h. Any other heart problem that you've been told about: ☐ **Yes** ☐ **No**

If you answered yes to any above question please explain and did you seek medical attention:

6. Have you ***ever had*** any of the following cardiovascular or heart symptoms?

a. Frequent pain or tightness in your chest: ☐ **Yes** ☐ **No**
b. Pain or tightness in your chest during physical activity: ☐ **Yes** ☐ **No**
c. Pain or tightness in your chest that interferes with your job: ☐ **Yes** ☐ **No**
d. In the past two years, have you noticed your heart skipping or missing a beat: ☐ **Yes** ☐ **No**
e. Heartburn or indigestion that is not related to eating: ☐ **Yes** ☐ **No**
f. Any other symptoms that you think may be related to heart or circulation problems: ☐ **Yes** ☐ **No**

If you answered yes to any above question please explain and list any medical attention you have received:

7. Do you ***currently*** take medication for any of the following problems?

a. Breathing or lung problems: ☐ **Yes** ☐ **No**
b. Heart trouble: ☐ **Yes** ☐ **No**
c. Blood pressure: ☐ **Yes** ☐ **No**
d. Seizures (fits): ☐ **Yes** ☐ **No**

If yes, please list medications:

8. If you've used a respirator, have you ***ever had*** any of the following problems? (If you've never used a respirator, go to question 9) :

a. Eye irritation: ☐ **Yes** ☐ **No**
b. Skin allergies or rashes: ☐ **Yes** ☐ **No**
c. Anxiety: ☐ **Yes** ☐ **No**
d. General weakness or fatigue: ☐ **Yes** ☐ **No**
e. Any other problem that interferes with your use of a respirator: ☐ **Yes** ☐ **No**

9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire?: ☐ **Yes** ☐ **No**

Questions 10 to 15 below must be answered by every employee/student who has been selected to use either a full-face piece respirator or a self-contained breathing apparatus (SCBA). For employees/students who have been selected to use other types of respirators, answering these questions is voluntary.

10. Have you ***ever*** lost vision in either eye (temporarily or permanently): ☐ **Yes** ☐ **No**

11. Do you ***currently*** have any of the following vision problems?

a. Wear contact lenses: ☐ **Yes** ☐ **No**
b. Wear glasses: ☐ **Yes** ☐ **No**
c. Color blind: ☐ **Yes** ☐ **No**
d. Any other eye or vision problem: ☐ **Yes** ☐ **No**

12. Have you ***ever had*** an injury to your ears, including a broken eardrum: ☐ **Yes** ☐ **No**

13. Do you ***currently*** have any of the following hearing problems?

a. Difficulty hearing: ☐ **Yes** ☐ **No**
b. Wear a hearing aid: ☐ **Yes** ☐ **No**
c. Any other hearing or ear problem: ☐ **Yes** ☐ **No**

14. Have you ***ever had*** a back injury: ☐ **Yes** ☐ **No**

15. Do you ***currently*** have any of the following musculoskeletal problems?

a. Weakness in any of your arms, hands, legs, or feet: ☐ **Yes** ☐ **No**
b. Back pain: ☐ **Yes** ☐ **No**
c. Difficulty fully moving your arms and legs: ☐ **Yes** ☐ **No**
d. Pain or stiffness when you lean forward or backward at the waist: ☐ **Yes** ☐ **No**
e. Difficulty fully moving your head up or down: ☐ **Yes** ☐ **No**
f. Difficulty fully moving your head side to side: ☐ **Yes** ☐ **No**
g. Difficulty bending at your knees: ☐ **Yes** ☐ **No**
h. Difficulty squatting to the ground: ☐ **Yes** ☐ **No**

i. Climbing a flight of stairs or a ladder carrying more than 25 lbs: ☐ **Yes** ☐ **No**
j. Any other muscle or skeletal problem that interferes with using a respirator: ☐ **Yes** ☐ **No**

Part B.

1. At work or at home, have you ***ever been exposed to*** hazardous solvents, hazardous airborne chemicals (e.g., gases, fumes, or dust), or have you come into skin contact with hazardous chemicals: ☐ **Yes** ☐ **No**

If "yes," name the chemicals if you know them:
_____
_____
_____

2. Have you ***ever worked with*** any of the materials, or under any of the conditions, listed below:

a. Asbestos: ☐ **Yes** ☐ **No**
b. Silica (*e.g.*, in sandblasting): ☐ **Yes** ☐ **No**
c. Tungsten/cobalt (e.g., grinding or welding this material): ☐ **Yes** ☐ **No**
d. Beryllium: ☐ **Yes** ☐ **No**
e. Aluminum: ☐ **Yes** ☐ **No**
f. Coal (for example, mining): ☐ **Yes** ☐ **No**
g. Iron: ☐ **Yes** ☐ **No**
h. Tin: ☐ **Yes** ☐ **No**
i. Dusty environments: ☐ **Yes** ☐ **No**
j. Any other hazardous exposures: ☐ **Yes** ☐ **No**

If "yes," describe these exposures:
_____
_____
_____

3. List any second jobs or side businesses you have:_____
_____
_____

4. List your previous occupations:
_____
_____
_____

6. List your current and previous hobbies:

_____
_____
_____

7. Have you been in the military services? ☐ **Yes** ☐ **No**

If "yes," were you exposed to biological or chemical agents
(either in training or combat): ☐ **Yes** ☐ **No**

8. Have you ***<u>ever worked</u>*** on a HAZMAT team? ☐ **Yes** ☐ **No**

9. Other than medications for breathing and lung problems, heart trouble, blood pressure, and seizures mentioned earlier in this questionnaire, are you taking any other medications for any reason
(including over-the-counter medications): ☐ **Yes** ☐ **No**

If "yes," name the medications if you know them

_____
_____
_____

Student is medically qualified to wear a N95 Respirator. ☐ **Yes** ☐ **NO**

_____ _____
Licensed Healthcare Provider's Name Date

_____ _____
Signature of Licensed Healthcare Provider Phone

_____
Address

Bio Reference
LABORATORIES

FINAL REPOR1

,ir. DPKD Ht◆JII.H Cc:- 10: . . :"

PHYSICIAN
GLUCKMAN, WILLIAM
J6625 · FASTER URGENT CARE
130 SPEEDWELL AVENUE,
MORRIS PLAINS, NJ 07950
Acct #: (J6625) 12
p: (862) 242-805_3

PATIENT
DOB: Age: Sex:
U/FL:
Bed:
Rm:
Patient ID:
Address:
P:

SAMPLE
Specimen ID:
Date Of Report: 12/0l/20D 03:47
Date Collected: 11/38/2017 17 :44
Date Received: 11/38/2017 21:l3
North America Eastern Time

Notes: NON FASTING

CLINICAL REPORT

Clinical Abnormalities Summary: (May not contain all abnormal results; narrative results may not have abnormal flags. Please review entire report.)

HEP. B SURF, AB. **Reactive •**

MISCELLANEOUS

Test	Result	Abnormal	Reference	Units	Prior Date	Prior Result
HEP. B SURF. AB.		Reactive *	Non-Reactive		12/01/17	

Hepatitis B Result Interpretation
(for reference use only)

Marker	LI/EA•	Acute	Past	Chronic	HBV vacc.
H8sAg	+	+	-		-
HBeAg	+	+	-	-+-/-	-
HEP.B.CORE AB,IgM	-	+	-	-	-
HEP.B.CORE AB.	-	+	+	+	-
HBeAb	-	-	+/-	+/-	-
HBsAb	-	-	+/-	-	+

+Late Incubation/Early Acute

NOTE: In remote past infection, HBsAb level may be Negative or Non-Reactive in some patients.

SAMPLE LAB REPORT
TITER VALUE INDICATION OF POSITIVE (IMMUNITY)

MUMPS VIRUS Ab.(IgG) 48.4 Immune >10.9 AU/ml 12/01/17 1

INTERPRETATION OF RESULTS FOR MUMP◆ IgG ANTIBODIES

Range (AU/ml)	Interpretation	
<9.8	Negative	Non-Immune
9,0-10.9	Equivocal	Retest
> or-=11.0	Positive	Immune

Results Intcr•pretcd as EQUrvOCAL indicate a level of antibody b<?lo,◆ t◆e posstivn(Immune)cut off. I.epeat testing on anv spucimen is suggC!s ted to assess antibody response after a booster shot or a viral syndrome.

NOTE: New reference range imple◆ntecf 11-16-17.

RUBEOLA/MEASLES(IgG (yJ Immune >29.9 AU/ml 12/01/17 /

INTERPRETATION OF RESULTS FOR RUBEOLA(MEASIES)IgG *ANTIBODIES*

PHYSICIAN
GLUCKMAN, WILLIAM
J6625 - FASTER URGENT CARE
130 SPEEDWELL AVENUE,
MORRIS PLAINS, NJ 07950
Acct #: (J6625) 12
p: (862)242-8053

PATIENT
DOB: Age: *sex:*
U/FL: Bed:
Rm:
Patient IO:
Address:
P:

SAMPLE
Specimen *ID:*
Date Of Report: **12/01/2017 03: *47***
Date Collected: **11/30/2017 17:44**
Date Received: **11/30/2017 21: 13**
North America Eastern Time

CLINICAL REPORT

Test	Result	Abnormal	Reference Units	RpT Date	Prior Result	Date

Range (AU/ml) Interpretatjon
<25.0 **Negative** Non-Immune
2S.0-29.9 Equivocal Retest
> or=30.0 Positive Immune

Results interpreted as EQUIVOCAL indicate *a* level of antibody below the positive(l111mune) cut off. Repeat testing on a new specimen is suggested *to assess* antibody response after a booster shot or a viral syndrome.

NOTE: New reference range implemented 11-16-17.

VARICELLA ZOS.(Ig<S) Immune>l64 Index .9 **12/01/17**

SAMPLE LAB REPORT
TITER VALUE INDICATION OF POSITIVE (IMMUNITY)

INTERPRETATION OF RESULTS FOR VARICELLA IgG ANTIBODIES

Range (Index) Interpretation
<135.8 •- Negative Non-Immune
135.8-164.9 Equivocal Retest
> or=165.8 Positive *Immune*

Results interpreted /JS EQUIVOCAL indicate a level of anti-body below the positive(Immune)cut off. Repeat testing on a new specimen is suggested to *assess* antibody response a-fter a booster shot or., viral syndrome.

NOTE: New reference range implemented 11-16-17,

RUSELLA,IgG Immune=)9. IU/ml 12/01/17
9

INTERPRETATION OF RESULTS FOR RUBELLA IgG *ANTIBOOY*

Results (IU/ml) Interpretation
< 5.0 Negative Non-Immune
S.e - *9.9* Equivocal Retest
> 9.9 Positive Immune

NOTE: Results interpreted as EQUIVOCAL indicate a *level* of antibody below the Positive (Immune) cut off. Repeat testing on a new specimen is suggested to **assess** antibody response after a booster shot or a viral syndrome.

ASSAY INFORMATION: Method Chemiluminescence *(Siemens* Diagnostics}

BASIC LIFE SUPPORT

BLS Provider

American Heart Association®

has successfully completed the cognitive and skills evaluations in accordance with the curriculum of the American Heart Association Basic Life Support (CPR and AED) Program.

Issue Date
3/16/2019

Recommended Renewal Date
03/2021

Training Center Name
HMH Central EMS Training Center

Instructor Name
Alexander Balish

Instructor ID
08110039118

Training Center ID
NJ00022

eCard Code
195501930039

Training Center Address
65 James St
Edison NJ 08820-3947 USA

QR Code

Training Center Phone Number
(732) 379-2794

To view or verify authenticity, students and employers should scan this QR code with their mobile device or go to www.heart.org/cpr/mycards.

CNA

HEALTHCARE PROVIDERS SERVICE ORGANIZATION PURCHASING GROUP

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OCCURRENCE POLICY FORM

nso

nu= Hrvlcc organuatioir

Print Date: 11/07/2017

Producer Branch Prefix	Policy Number	Polley Period
018098 970 HPG		from 11/10/17to 11/10/16at 12:01 AM Standard Time

Named Insured and Address:

Program Administered by:
Nurses Service Organization
158 E. County Lino Road
Hatboro, PA 19040-1210
1-000-247•1500
www.nso.com

Medical **Specialty:** Registered Nurse Student

Code: 80964

Insurance Is provided by:
Amef'lcan Casuj!fty Company *of* Reading, Pennsylvania
333 S. Wabasll"Avenue, Chicago, Il 60604

Professional Uabilfty	**$1,000,000 each claim**		**$ 6,000,000 aggregate**

Your professional llablllly limits shown above Include the following:
- Good Samaritan Liability
- Malplaoement Uabi ly.
- Parson o Injury Llablllty
- Sexual Misconduct Included In the PL llmlt shown above subject to $ 25,000 aggregate sublimll

Coverage Extensions

Defendant Expense Benefit	$ 1,000	per day limit	$25,000	aggregate
Deposition Representation	$ 10,000	per deposition	$10,000	aggregate
Assault	$ 25,000	per incident	$25,000	aggregate
lnolUde& Workplace Violence Counseling				
First Aid	$ 10,000	per Incident	$10,000	aggregate
Damage to Property 0 Others	$ 10,000	per Incident	$10,000	aggregate
Information Privacy (HIPAA) Fines and Penalties	$25,000	per inoident	$25,000	eagregate

Total: $ 35,21

Base Premium $ 35.00 **Surcharge $ .21** **Looal Tax $0,00**

Policy Fo,ms & Endorsements(Please see attached fist for a general desoripUon of many common poltcy forms end endorsements.)

G-121500-O G-121501•C GSL15563 GSL15564 GSL15565 GSL17101 GSL13424NJ
CNA60051 CNA80052 G-12384S.C29 CNA84406

Chairman of the Board

Secretary

Koop this documonl In o soro placo.lt ond proofofpayrnont oro your proof of covarago. 111ore Is no covorogo In forco untoss tho prom/um is pold in full.In ardor to act/'(O(o your covarogo, pleaao romfi promium *In* tun by tho ofTaclil/o doto of this Curt/floats of Insuranco.

Master Polley # 108711433

CM41241•B(03/2010)

Coverage Change Date:

Endor.iement Change Dalo: